COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1963

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

INDEX

HEALTH COMMITTEE, 1963

Chairman: Alderman R. F. Dickinson, J.P.

Vice-Chairman: Alderman Mrs. E. G. Cain, O.B.E., J.P.

Aldermen:

Curwen, Mrs. J. N. St. G., J.P.
McCann, Rev. F. K.
Stephenson, W., J.P.
Wilson, D. G., J.P.

Councillors:

Askew, J.
Bainbridge, J. J.
Barton, Dr. E. B.
Bland, T. P., J.P.
Dickinson, D. L.
Dixon, W.
Gaffney, C.
Johnston, T. W.
Kilbride, J.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Nixon, W. G., J.P.
Perrott, Dr. E. A.
Smith, Mrs. M., J.P.
Thomas, H.
Vane, Mrs. M. F., J.P.
Wilson, Mrs. M. A., J.P.

Ex-Officio Members:

Chairman of County Council: Westoll, J., J.P.

Vice-Chairman of County Council: Edmonds, C., J.P.

Chairman of Finance Committee: Highton, L., J.P., D.L.

External Members:

Bowman, G.
Cartmel, Mrs. M. C.
Collins, R. G.
Douglas, Mrs. M.
Edington, Dr. E. M.
Ferguson, Dr. T. T., J.P.
Fletcher, Dr. A. F.
Grant, Dr. R. N. R.
Hasell, Mrs. G., O.B.E., J.P.
Hodgson, Mrs. H. L.
Long, R.
Ritson, C., J.P.
Whiteley, Miss D. I.
Wood, Mrs. C. H.
Young, A., M.B.E.

PREFACE

To the Chairman and Members of the Cumberland County Council.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report on the Health of the County of Cumberland during the year 1963.

The health of the Cumbrian remains extremely good, and the vital statistics for the year underline this statement. The death rate is 12.5 per thousand population which is the average figure for the last decade, and which is satisfactory considering the population structure.

At the younger end of the age scale the perinatal mortality rate, which is the most delicate indicator of the efficiency of the maternity service as a whole, is, after many years' attempts to lower it, at a low figure which approximates to the national. The quarterly meetings of both Local Maternity Liaison Committees have been of the greatest value and great progress has been made in the prevention of still births and early neo-natal deaths. I consider that future years may well show that the significant improvement in the trend of this rate in this County came in 1963.

The infant mortality rate also is at a figure never thought possible in the past—21.9 infant deaths per 1,000 live births, and a close analysis of the infant death statistics shows that the wastage of child life occurs mostly in first week of life.

I feel, however, that I should first draw your attention to an important point in the statistics relating to social conditions in the County. It concerns the net outward migration from the County, which commenced some forty years ago and which has continued fairly constantly to influence the population statistics ever since.

The population trend in the northern part of the Western industrial belt can be described as showing a low population increase, low natural increase and a net outward migration against a background of static or declining employment. In the southern

part of West Cumberland there has been a higher population increase, high natural increase, inward migration and increasing employment especially of males. In the Eastern part of the County —an essentially rural area—there was, in general, a natural increase and net outward migration.

This indicates a trend in depopulation which tends to make the work of caring for the less effective but static members of the community, especially in the rural areas where this trend is more marked, harder for the Health and Welfare Department.

I would like to underline three points in the vital statistics. The first is that the birth rate has dropped from a figure of 18.3 to 17.7 per 1,000 population—this being against the national trend.

The second is that the total numbers of middle aged men between the ages of 45 and 64 who died in the year is still substantially the same in this County as it was some 50 years ago, although the causes of death are different. What would be the outcry if the same sombre facts were true of other groups in the community—say, mothers and infants?

The third point evidenced in the vital statistics is that the number of deaths in the year from lung cancer has increased from 66 to 98, and this site (lung) is the only one in which deaths from this disease are increasing.

I have emphasised the rather dark sides of the picture—one which in general can be painted in the lightest of colours, as one would expect in a County with no real atmospheric pollution. The atmospheric pollution gauges which the Authority have bought and installed on Dean Moor and at Thursby in association with the Department of Scientific and Industrial Research are to help find a natural base line, for pollution of the air in the whole of England and Wales. The County has, surprisingly, a minimum of bad weather with plenty of sunshine, and the unalloyed and undoubted scenic attractions of the English Lakes, together with the mild weather especially in the Western coastal area, no doubt associated with the effects of the gulf stream, obviously make it a most desirable locality for new industry.

It is becoming increasingly obvious in day to day work of the Health and Welfare Department that the fundamental concept is that all medical and nursing care outside the hospital constitutes the main part of community care, and that in the years to come there is going to be a great increase in such community care in this County. The basic reason in support of community care is that a therapeutic effect is obtained merely by the presence of an unwell or inadequate person in the community.

It is doubtful to me whether the general public, the patient or the patient's family, some of those working in the other branches of the Health Services, or, indeed some working in the voluntary bodies, have either fully accepted or fully realised the fundamental nature of the impact on life in the future of this concept of community care.

It would appear that in future years patients will be admitted to hospital only when in need of either diagnosis or in-patient treatment, and when this is completed, they will be discharged home for care by the family doctor supported by all the local health authority staffs and voluntary help—i.e. community care.

Community care will be most obvious amongst the groups which have always caused public health interest and anxiety—mothers with their children; the handicapped; the large number of the mentally disordered, including those mentally ill and those mentally sub-normal, and lastly, the constantly increasing group of geriatric cases maintained in the community.

My thoughts now spread to the fact that the community itself, altering as it will by the incorporation of these groups, including social ineffectives or inadequates, will have to change.

The concept of one health service operating in an area with planned components from the hospital and consultants, general medical services and the local health authority, together with a planned voluntary ingredient, is one that is now being more fully accepted in this County. I have welcomed during the year the increasing interest and helpful co-operation of my general practitioner colleagues in the work of the Department. The amount of

social support and friendly visiting that is undertaken by members of voluntary organisations, is both effective and on a grand scale and is worthy of the highest praise.

A Health and Welfare department must undertake research if it is going to be dynamic and efficient, and during the year three research projects have been carried out—a survey of a random sample of persons over the age of 75 in the County in regard to their ecology; an investigation into causes of dental decay in children; and the survey on the future use of, and community attitudes to, child welfare centres.

I now wish to review various points in the services. Firstly in the nursing service, where the link with the family doctor has been strengthened, at the end of the year almost all the full-time health visitors were seconded to family doctor groups, with varying degrees of enthusiasm but almost invariable success. A start was being made with the secondment of domiciliary nurses, and an even closer link between the general practitioner-obstetrician and the domiciliary midwife was being actively examined. Also links forged in the past with hospitals, have been strengthened in the year. It was hoped that a more intimate association between the general practitioner and the child welfare clinics would be established. It is now completely apparent that there is a changing pattern of nursing in the County, and less importance will be placed in the future, on a nursing area, and more on the nurse associated with a particular general practitioner group. The standard of the public health nursing service in this County is undoubtedly the finest possible and one of which the County is understandably intensely proud.

Proceeding to the dental service in Cumberland, where for many years there has been a full establishment of dental officers, it is clear that good progress has been made by the holding of a three months' course in orthodontics. This training of dental

officers has given all professional staff an added enthusiasm and interest, which has followed their increased active participation in orthodontic treatment in children.

Turning to Welfare, where it is especially in the welfare of the elderly that most progress has been made, the concept of the community care of handicapped groups, based on the neighbourhood care homes, has been implemented.

The 1959 Mental Health Act is now settling down in its administration and the pilot secondment of Mental Welfare Officers to General Practitioner groups, so that pre, as well as after-care, may be given to cases of mental disorder, has been successfully started and gives me hope that pre-care may some day play a larger part in the prevention of mental breakdown.

Lastly, the ambulance section in the department has run a pilot advanced training course, in advance of the national recommendation, and here I am greatly indebted to all of the hospital consultants who so willingly and admirably gave of their time at this course.

The year has shown an increase in the use of the Hospital Car Service and great progress has been made in the establishment of a direct, rather than a contractual ambulance service throughout the county.

My final observation is that after some 15 years of the National Health Service it is also becoming apparent to many administrators, including myself, that the possibilities envisaged in the Porritt Report where there is a unified administration for the three branches of the National Health Service, offer a field of thought and discussion which may well be rewarding.

My thanks are due to the members of the Council, especially the Chairman of the Health Committee, to my fellow heads of departments of the Council, and last, but by no means least, to all members of the Health Department whose sheer hard work, enthusiasm and concentration have been invaluable in a year of such progress.

I am, Ladies and Gentlemen,

Your Obedient Servant,

John Leiper.

County Medical Officer.

County Health Department,
11, Portland Square,
Carlisle.
Telephone No. Carlisle 23456.

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and County Welfare Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Assistant County Medical Officers, and District Medical Officers of Health—

J. L. Hunter, M.B., Ch.B., D.P.H., Senior Assistant County Medical Officer and Medical Officer of Health, Workington Borough.

A. Crowley, M.B., B.Ch., D.Obst.R.C.O.G., D.P.H., Medical Officer of Health, Millom Rural District.

J. N. Dobson, M.B., Ch.B., D.P.H., Medical Officer of Health, Whitehaven Borough and Ennerdale Rural District.

J. R. Hassan, M.B., Ch.B., D.Obst.R.C.O.G., Medical Officer of Health, Alston Rural District (also general practitioner).

J. Patterson, M.B., B.Ch., B.A.O., D.P.H., Medical Officer of Health, Cockermouth Rural and Urban Districts and Keswick Urban District.

H. C. T. Smith, M.B., Ch.B., D.P.H., D.P.A., Medical Officer of Health, Wigton Rural District and Penrith Urban District.

K. J. Thomson, M.B., Ch.B., D.P.H., L.M., Medical Officer of Health, Border Rural District and Penrith Rural District.

Assistant County Medical Officers—

J. E. Ainsworth, M.B., Ch.B. (Commenced 30.9.63).

E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. and H.

C. H. Mair, L.R.C.P., L.R.C.S.(Ed.), D.P.H. (Resigned 21.6.63).

E. M. Spencer, M.B., Ch.B.

M. Timperley, M.B., Ch.B.

DENTAL

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

J. A. G. Baxter, L.D.S.R.C.S.
M. Green, L.D.S.R.C.S. (Commenced 1.1.64).
D. H. Hayes, L.D.S.
M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
A. MacDonald, L.D.S. (Resigned 2.11.63).
I. H. Parsons, L.D.S.
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.R.F.P.S.
A. M. Scott, L.D.S.

WELFARE SERVICES

Welfare Services Officer—

S. Hodgson, F.C.C.S.

Welfare Officer—

F. Lewthwaite.

Part-time Welfare Officers—

A. Corlett.
J. Gibson.
J. Housby.
A. Irving.
D. W. Jack.
J. D. Messenger.
G. A. H. Miller.
L. M. Robinson.
W. H. Robinson.

Manager/Matron of Residential Accommodation—

Mrs. H. M. Abbott, Castle Mount, Egremont.

Mrs. F. Davies, Derwent Lodge, Papcastle.

G. C. Dryell, Station View House, Penrith (Resigned 20.7.63).

H. C. Allen, Station View House, Penrith (Commenced 19.8.63).

Miss B. Edgar, Grange Bank, Wigton.

Mrs. A. Hill, Parkside, Maryport (Resigned 22.5.63).

Miss A. G. Ross, S.R.N., Parkside, Maryport (Commenced 1.7.63)

P. A. Howe, Highfield House, Wigton.

Mrs. K. L. Lewthwaite, S.R.N., S.C.M., Richmond Park, Workington.

Miss E. M. Rodgers, The Croft, Kirksanton (Resigned 30.6.63).

Miss E. Knox, The Croft, Kirksanton (Commenced 1.7.63).

Mrs. D. Smitham, S.R.N., Garlieston, Whitehaven.

Miss V. Woodman, S.R.N., The Towers, Skinburness.

Warden of Calthwaite Reception Centre—

F. C. Murdoch.

Social Worker/Craft Instructor—

C. Robinson.

Home Teachers for the Blind—

Miss J. Burgess.

Miss L. D. Fraser.

Miss A. I. Hetherington.

Miss G. Jones (Resigned 6.9.63).

Miss G. Mitchell.

Miss I. O'Grady (Commenced 23.9.63).

MENTAL HEALTH

Consultant Psychiatrists (Part-time) seconded from Newcastle-upon-Tyne Regional Hospital Board—

J. R. Stuart, M.B., Ch.B., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Mental Health Officer—

N. Froggatt.

Senior Mental Welfare Officer—

E. L. Mayoh, A.A.P.S.W. (Resigned 29.11.63).

Mental Welfare Officers—

A. M. Bradley, S.R.N., R.M.N.
G. Cowham, R.M.N.
J. A. Denton, S.R.N., R.M.N.
Miss E. F. Hall.
M. H. Payne.
J. C. Tanti.
Miss E. Welch, A.A.P.S.W.

Training Centre Supervisors—

Miss G. L. Lister, Whitehaven.
Miss N. Macpherson, Wigton.

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—

Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N., H.V. Cert.

Assistant Superintendent Nursing Officers—

Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert., P.H.Admin.Cert. (resigned 30.6.63).

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert. (Commenced 1.8.63).

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

Miss M. G. M. Watson, S.R.N., S.C.M., Q.N., H.V.Cert., R.F.N.

NURSES' QUALIFICATIONS CODE

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. Queen's Nurse.
4. Health Visitor's Certificate.
5. Registered Fever Nurse.
6. State Enrolled Nurse.
7. Registered Sick Children's Nurse.
8. Orthopaedic Nursing Certificate.
9. Diploma in Tropical Nursing.

Health Visitors—

East Cumberland

Miss A. Dixon, 1, 2, 4.	Penrith.
Miss B. W. Knibbs, 1, 2, 3, 4.	Brampton.
Mrs. M. McCredie, 1, 2, 4.	Penrith.
Mrs. A. W. E. Maughan, 1, 2, 4.	Longtown.
Miss E. Mercer, 1, 2, 4, 5.	Wigton.
Mrs. M. C. Roberts, 1, 2, 4.	Aspatria.

West Cumberland

Miss G. Davies, 1, 3, 4.	Workington.
Mrs. B. L. Goodson, 1, 2, 4.	Workington.
Mrs. M. Hewitson, 1, 2, 4.	Workington.
Miss M. McCann, 1, 2, 3, 4.	Workington.
Miss J. E. Surtees, 1, 2, 4.	Workington.

South Cumberland

Miss I. M. Alcock, 1, 2, 4.	Whitehaven.
Mrs. S. Bowe, 1, 2, 4.	Whitehaven.
Miss E. Crosby, 1, 2, 4.	Egremont.
Miss A. M. Greggain, 1, 2, 3, 4.	Cleator Moor.
Miss R. A. Lodge, 1, 2, 4.	Whitehaven.
Mrs. A. Petch, 1, 2, 3, 4.	Whitehaven.
Miss R. Sheppard, 1, 2, 3, 4.	Cleator Moor.
Miss P. Walsh, 1, 2, 4.	Egremont.

All the above are seconded to general practitioners.

Miss M. E. Gibson, 1, 2, 4.	Full-time T.B. Health Visitor.
Mrs. M. Lythgoe, 1, 2, 4.	Full-time T.B. Health Visitor.
Miss M. Horn, 1, 2, 4, 5.	Cockermouth. To be seconded 1964.
Miss F. Kendall, 1, 2, 4.	Maryport. To be seconded 1964.
Miss A. M. Little, 1, 2, 4.	Millom. To be seconded 1964.
Miss S. Twigg, 1, 2, 3, 4.	Maryport. To be seconded 1964.

District Nurse/Midwives—

East Cumberland

Miss E. M. Dixon, 1, 2, 3.	Longtown.
Miss J. Gibbs, 1, 2, 3.	Longtown.
Miss E. C. Guthrie, 1, 2, 3, 9.	Silloth.
Miss A. M. Holliday, 1, 2, 3.	Aspatria.
Mrs. F. M. Hurst, 1, 2, 3.	Brampton.
Mrs. M. Jackson, 2, 6.	Penrith.
Mrs. I. Penn, 1, 2, 3.	Penrith.
Miss A. Stidson, 1, 2, 3.	Alston.
Mrs. M. E. Wilde, 1, 2, 3.	Relief.
Miss K. Winter, 1, 2, 3.	Penrith.

West Cumberland

Miss M. G. Beattie, 1, 2, 3.	Great Clifton.
Miss A. Chadwick, 1, 2, 3.	Maryport
Mrs. C. M. Gate, 1, 2, 3.	Maryport.
Miss A. I. Kirk, 1, 2, 3.	Cockermouth.
Mrs. H. M. McCallam, 2, 6.	Relief.
Miss M. Musgrave, 1, 2, 3.	Cockermouth.
Miss O. Pickering, 1, 2, 3.	Maryport.

South Cumberland

Miss A. Armstrong, 1, 2, 3.	Egremont.
Mrs. I. Booth, 1, 2.	Relief.
Miss C. O. Grosvenor, 1, 2, 3, 4.	Millom.
Miss C. E. Hall, 1, 2, 3.	Egremont.
Miss F. Lonsdale, 1, 2.	Seascale.
Miss M. Proctor, 1, 2, 3.	Frizington.
Miss H. Spencer, 1, 2, 3.	Frizington.
Miss D. Waterhouse, 1, 2, 3.	Millom.
Mrs. J. White, 2, 6.	Egremont.

Midwives—

Workington

Mrs. S. Fields, 1, 2.	Mrs. A. Maguire, 2.
Mrs. M. M. Hind, 2, 6.	Mrs. M. K. Tunstall, 1, 2.

Whitehaven & Cleator Moor

Mrs. M. Ainsworth, 1, 2.	Miss A. Singleton, 1, 2
Miss E. M. Miller, 1, 2, 3.	Miss M. Stephenson, 1, 2, 3.

District Nurse/Midwife/Health Visitors—

East Cumberland

Miss I. Arnott, 1, 2, 3, 8.	Threlkeld.
Miss M. A. Barclay, 1, 2, 3, 5.	Greystoke.
Mrs. E. C. Barnes, 2, 6.	Lanercost.
Miss A. Bowler, 1, 2, 3, 4.	Caldbeck.
Miss J. R. N. Byres, 1, 2, 3, 5.	High Hesket.
Miss E. M. Chalkley, 1, 2, 3.	Langwathby.
Miss A. A. Cockton, 1, 2, 3, 5.	Burgh-by-Sands.
Mrs. M. Dobson, 1, 2, 3, 4	Houghton.
Miss L. R. Douglass, 2, 6.	Skelton.
Mrs. F. A. Gaskin, 1, 2, 3.	Irthington.
Miss C. H. Greaves, 1, 2, 3.	Lazonby.
Mrs. M. Hedworth, 1, 2, 3.	Abbeytown.

Miss E. Henderson, 1, 2, 3.	Langwathby.
Mrs. D. M. Lancaster, 1, 2, 3, 4.	Wigton.
Miss F. M. McGrath, 1, 2, 3.	Dalston.
Mrs. M. J. Mathews, 1, 2, 3, 4.	Watermillock.
Miss A. M. M. Penman, 1, 2, 3, 4.	Thursby.
Mrs. E. E. Rome, 2, 6.	Kirkbride.
Mrs. M. Sanderson, 1, 2, 3, 4.	Alston.
Miss N. D. Sanderson, 1, 2, 3, 4.	Bewcastle.
Miss P. B. Simpson, 1, 2, 3, 4.	Wigton.
Miss E. M. Wallace, 1, 2, 3.	Wetheral.
Miss M. Weightman, 1, 2, 3.	Scotby.
Miss B. M. Wesson, 1, 2, 3.	Hayton.

West Cumberland

Mrs. C. Butcher, M.B.E., 1, 2, 3, 5.	Bassenthwaite.
Miss M. Casey, 1, 2, 3, 4.	Keswick.
Mrs. A. Donald, 1, 2, 3, 4, 7.	Oughterside.
Miss S. J. Graham, 2, 6.	Brigham.
Mrs. M. Hall, 2, 6.	Relief.
Miss J. M. Hillhouse, 1, 2.	Keswick.
Miss R. Hobbiss, 1, 2, 3, 4.	Lorton.
Mrs. N. Hodgson, 2, 6	Broughton.
Miss S. M. J. Iliffe, 1, 2, 3.	Borrowdale.
Miss C. F. M. McKnight, 1, 2, 3, 4.	Dearham.
Miss R. W. Ventress, 1, 2, 3, 4.	Bothel.

South Cumberland

Mrs. I. E. Bowe, 1, 2, 3, 4.	Bootle.
Mrs. J. A. Graham, 1, 2, 3, 4.	Distington.
Miss J. A. G. Hardie, 1, 2, 3, 4.	Parton.
Miss D. D. James, 1, 2, 3, 4.	Seascale.
Mrs. M. Marshall, 1, 2, 3.	Muncaster.
Miss A. M. Mackay, 1, 2, 3, 4.	Lamplugh.

District Nurses—

East Cumberland

Mrs. J. A. Branthwaite, 1.	Relief.
Mrs. R. M. Gultnieks, 6.	Relief.
Mrs. M. Hope, 1, 2.	Relief.
Mrs. E. J. Relph, 1, 3.	Penrith.

West Cumberland

Mrs. J. E. Barnes, 1, 2, 3.	Relief.
Mrs. E. Fagan, 1, 3.	Workington.
Mr. T. D. Holmes, 1, 3.	Workington.
Mrs. M. I. Lowis, 1, 3.	Workington.
Mrs. L. Messenger, 1, 2, 3.	Workington.
Mrs. S. E. Scott, 2, 6.	Relief.
Miss M. Young, 1, 2, 3, 7.	Workington.

South Cumberland

Mr. D. Amour, 1, 6.	Whitehaven.
Mrs. E. Brannon, 1, 3.	Whitehaven.
Miss O. G. Coates, 1, 3.	Whitehaven.
Mrs. G. Connolly, 1, 2.	Relief.
Mrs. F. Corkhill, 1, 3.	Egremont.
Mrs. H. Egan, 1, 5.	Relief.
Mrs. D. Jolly, 1, 2, 5.	Relief.
Mrs. I. Routledge, 1, 2, 3.	Whitehaven.
Mrs. M. T. Toole, 1, 3.	Cleator Moor.
Miss J. Woodend, 1, 3.	Whitehaven.

School/Clinic Nurses—

Mrs. E. M. Maguire, 1, 2, 8.	Whitehaven.
Mrs. M. E. Sansom, 1, 2, 5.	Relief.
Mrs. B. F. Wilson, 1.	Whitehaven.
Mrs. M. K. Wilson, 1.	Relief.
Miss D. Wise, 1, 2, 3, 5, 9.	Workington.

Audiometricians—

Mrs. M. G. Hicks.
Mrs. D. Gaughy.

Chiropodist—

G. H. Thomas, M.Ch.S.

Orthopaedic Physiotherapists—

Miss J. M. Morris, M.C.S.P., M.E.
Miss J. A. Fraser, M.C.S.P., O.N.C.

Orthoptist—

Mrs. S. Richardson, D.B.O. (Part-time) (Resigned 31.7.63)
Mrs. G. Richardson, D.B.O. (Part-time) (Commenced 21.10.63)

Speech Therapists—

Miss C. M. Allan, L.C.S.T. (Resigned 31.2.63.)
Mrs. E. M. Blacklock, L.C.S.T
Miss E. B. Moon, L.C.S.T.
Mrs. S. Latimer, L.C.S.T. (Part-time) (Commenced 30.4.63).
Mrs. M. V. Aitchison, L.S.C.T. (Part-time) (Commenced 5.11.63).

County Ambulance Officer—

M. F. Smith

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

ADMINISTRATION

The administration of the County Health Service by the local health authority—the County Council—is through the Health and Housing Committee, which, in turn, has four standing sub-committees—General Purposes, Nursing, Mental Health and Welfare. In addition there is a Joint Health and Education Sub-Committee, which has representatives of both the Health and Education Committees, to deal with matters relating to the health of school children, and a Joint Committee of representatives of the County and Carlisle Authorities to administer the Workshops for the Blind. To ensure a wide variety of interests and lines of thought, the Health and Housing Committee has 15 members who are not County Councillors and who represent the medical, dental, pharmaceutical and nursing professions, the Hospital Management Committees and voluntary organisations, in addition to the 26 elected representatives appointed by the County Council.

Apart from certain day to day matters mostly affecting the school health service in West and South Cumberland, which are conducted by the Senior Assistant County Medical Officer in the Area Office in Whitehaven, the remainder of the administrative work is carried out from headquarters office in Carlisle. At the end of the year there were 46 administrative and clerical staff, of whom 10 were in the Area Office at Whitehaven. In addition, the Assistant Medical Officers who were also Medical Officers of Health had the assistance of clerks on the staffs of the District Councils for their County work. Part of their salaries are paid by the County Council and in aggregate they amount to the equivalent of two full time clerks.

The headquarters staff are organised in six main sections; welfare, nursing services, school health, ambulance, mental health and general purposes, each with an administrative assistant in charge except welfare, where there is a Welfare Services Officer. There is an administrative assistant in charge of the clerical work in the Whitehaven Office and, lastly, the dental section at headquarters has come clerical assistance.

The regular two monthly meetings of Assistant County Medical Officers have continued, as have meetings of Mental Welfare

Officers, Managers and Matrons of Residential Homes, Home Teachers of the Blind and the staff of Training Centres. I am sure these conferences serve a most useful purpose.

My Deputy and I have continued to be able to attend meetings of a number of Committees such as the Special Area Committee, the West Cumberland Hospital Management Committee, Garlands Hospital Medical Advisory Committee, the Local Medical Committee and Local Maternity Liaison Committees.

Another way in which the administration of the services helped by the connections outside the County Council is the joint appointment of Assistant County Medical Officers who work for half their time as District Medical Officers of Health. There are undoubtedly advantages in such an arrangement and the delegation of welfare functions to these medical officers during the course of the year has helped to close the gap between the District and the County duties. For a number of years Maryport Urban District Council has been the only district with a Medical Officer of Health who was not also an Assistant County Medical Officer but when he retired a full time Assistant County Medical Officer began to work two sessions a week on district work.

The authority has continued to be more fortunate than most with staffing and, with two exceptions, has been in a happy position for some time. The only two services seriously affected have been speech therapy and orthoptics. For the seceond year there has been no full-time orthoptist in post although there is an establishment for two, and it has only been possible to get part-time assistance amounting to four sessions per week by employing an orthoptist from a considerable distance away who has to make a long journey. I am indebted to Mrs. G. Richardson for being prepared to do this and so keep at least an emergency service going. Repeated advertising for full-time orthoptists has brought no results and it seems that there is little prospect of improving this situation unless girls from Cumberland undertake the necessary training and return to the County or unless a training school can be established in the area. It may be that a scholarship scheme such as is already in being for mental welfare officers and health visitors would help.

When there have been orthoptists in post they have been seconded to the Hospital Management Committees for an appreciable part of their time, and in an attempt to alleviate the present difficulties by recruiting orthoptists who may be more attracted by hospital work than local authority work a reversal of the arrangement is to be tried.

The difficulties with which the authority has been faced by being one speech therapist short out of three throughout the year was greatly increased by an unfortunate accident to another, Miss E. B. Moon, who was seriously injured in a car accident in January while on duty and was not able to return until November. Even then she was able to work only two sessions a week but it is hoped that she will gradually be able to increase this. Meanwhile, it is a matter of dealing with high priority cases only. Every effort has been made to recruit staff but the only recruitments have been Mrs. S. E. Latimer, who works one session per week in Carlisle and Mrs. M. V. Aitchison, who undertakes sessional work at Cockermouth. I am particularly grateful for Mrs. Aichison's assistance in keeping the service alive in West Cumberland.

It is probable that this is the last occasion on which I will report the present Committee structure and method of administration. During 1963 the County Council, in a review of Committees, decided that while the functions of the local health authority should continue to be exercised through the Health and Housing Committee, from the date of the County Council elections in 1964 the Sub-Committees dealing with services would be replaced by all-purpose Area Committees. There will be three such Area Committees, Northern, Western and Southern, each covering an area with about 75,000 population. Each will appoint a House Sub-Committee to supervise the day to day management of all Health and Welfare residential establishments in the area. The Joint Health and Education Sub-Committee will continue in being but it is hoped that it will in future consider a wider variety of subjects than hitherto. Matters of health education in which the staff of the Education Committee can play a part will be considered, alongside the traditional affairs of the school health service. The Joint Sub-Committee will have a fair proportion of teacher representation.

It is expected that this reconstruction of the Committee arrangements will lead to the establishment of area administration in the latter part of 1964. This has already been approved in principle and detailed proposals are being prepared for consideration immediately after the new Committee comes into being.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054 acres.

Rateable Value (April 1st, 1963)—£6,172,972.

Estimated product of 1d. rate (1963-64)—£26,444.

Population (Census, 1951)—217,540.

Population (Census, 1961)—223,050.

Population (1963 Mid-year estimate)—224,630.

Live Births—Number	3,964
Rate per 1,000 population	17.7
Illegitimate live births per cent. of total births	4.9
Still Births—Number	76
Rate per 1,000 total live and still births	18.8
Total live and still births	4,040
Infant deaths (deaths under 1 year)	87
Infant mortality rates—	
Total infant deaths per 1,000 total live births ...	22.0
Legitimate infant deaths per 1,000 total legitimate births	21.8
Illegitimate infant deaths per 1,000 total illegitimate births	25.5
Neo-natal mortality rate (deaths under 4 weeks per 1,000 total live births)	18.4
Early neo-natal mortality rate (deaths under 1 week per 1,000 total live births)	15.1
Perinatal mortality rate (Still births and deaths under 1 week combined per 1,000 total live and still births)	33.7
Maternal Mortality (including abortion)	—
Rate per 1,000 total live and still births	—

A more detailed analysis of the above figures is given overleaf.

	Male	Female	Total	Urban Districts	Rural Districts	Admin. County	Eng'd and Wales (prov.)
LIVE BIRTHS—							
Legitimate ...	1958	1810	3768				
Illegitimate ...	105	91	196				
	2063	1901	3964				
Birth rate per 1,000 population ...				16.8	18.2	17.7	18.2
STILL BIRTHS—							
Legitimate ...	37	37	74				
Illegitimate ...	1	1	2				
	38	38	76				
Still birth rate per 1,000 total births ...				23.6	15.8	18.8	17.3
DEATHS—							
All causes ...	1493	1320	2813				
Death rate per 1,000 population ...				11.7	13.1	12.5	12.2
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	39	43	82				
Illegitimate ...	4	1	5				
	43	44	87				
Total infant deaths per 1,000 total live births				15.0	26.3	22.0	20.9

MORTALITY TRENDS IN CUMBERLAND

Year		Under 1	1—	5—	15—	25—	45—	65—	75+	Total
1923	...	344	177	110	106	308	584	559	605	2793
		12.3%	6.3%	4.0%	3.8%	11%	20.9%	20.0%	21.7%	Rate 12.7
1933	...	229	88	66	121	288	635	667	712	2806
										Rate 13.7
1953	...	97	15	18	32	135	560	717	997	2571
										Rate 11.9
1954	...	98	21	16	24	91	543	743	1031	2567
										Rate 11.9
1955	...	101	7	15	22	79	607	737	1075	2648
										Rate 12.2
1956	...	112	12	18	24	112	571	719	1085	2653
										Rate 12.2
1957	...	103	21	19	33	120	553	734	1057	2640
										Rate 12.1
1958	...	108	18	9	24	113	607	677	1087	2643
										Rate 12.1
1959	...	82	8	16	27	81	575	712	1110	2611
										Rate 11.9
1960	...	91	13	19	21	105	554	677	1149	2629
										Rate 12.0
1961	...	88	7	19	19	86	570	747	1189	2725
										Rate 12.3
1962	...	108	15	13	15	114	574	759	1125	2723
										Rate 12.2
1963	...	87	8	11	33	97	648	721	1208	2813
		3.1%	0.3%	0.4%	1.2%	3.5%	23.0%	25.6%	42.9%	Rate 12.5

BIRTHS

District		Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)
URBAN DISTRICTS—					
Cockermouth	...	87	5	92	15.5
Keswick	...	56	7	63	13.7
Maryport	...	187	11	198	16.1
Penrith	...	166	10	176	16.3
Whitehaven	...	472	28	500	18.1
Workington	...	478	22	500	16.8
Aggregate	...	1446	83	1529	16.8
RURAL DISTRICTS—					
Alston	...	24	—	24	11.7
Border	...	485	29	514	16.7
Cockermouth	...	330	14	344	16.5
Ennerdale	...	645	30	675	21.2
Millom	...	264	10	274	18.3
Penrith	...	179	9	188	16.4
Wigton	...	395	21	416	19.2
Aggregate	...	2322	113	2435	18.2
Administrative County	...	3768	196	3964	17.7

POPULATION IN THE YEAR 1963

DEATHS			INFANT MORTALITY				
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Legitimate	Illegitimate	Total	Deaths of Infants under 1 year per 1,000 live births	Estimated mid-year population
70	11.8	1.09	—	—	—	—	5950
81	17.6	0.83	3	—	3	47.6	4600
151	12.3	1.18	5	—	5	25.3	12310
131	12.1	0.96	3	—	3	17.0	10790
280	10.2	1.25	5	—	5	10.0	27600
353	11.8	1.18	7	—	7	14.0	29810
1066	11.7	1.14	23	—	23	15.0	91060
33	16.0	0.86	2	—	2	83.3	2060
452	14.7	0.98	12	1	13	25.3	30740
237	11.3	1.10	9	—	9	26.2	20880
397	12.5	1.25	16	2	18	26.7	31840
178	11.9	1.26	7	—	7	25.6	14980
142	12.4	1.03	4	—	4	21.3	11430
308	14.2	0.97	13	2	15	36.1	21640
1747	13.1	1.08	59	5	64	26.3	133570
2813	12.5	1.10	82	5	87	22.0	224630

	Cause of Death	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.
	All Causes	2813	70	81	151
1.	Tuberculosis, Respiratory	5	—	—	—
2.	Tuberculosis, Other	1	—	—	—
3.	Syphilitic disease	2	—	—	1
4.	Other infective and Parasitic diseases ...	3	—	—	—
5.	Malignant neoplasm, stomach	72	—	1	6
6.	Malignant neoplasm, lung bronchus ...	98	1	1	4
7.	Malignant neoplasm, breast	36	2	1	—
8.	Malignant neoplasm, uterus	16	—	—	1
9.	Other malignant and lymphatic neoplasms	212	6	3	15
10.	Leukaemia, Aleukaemia	9	—	1	1
11.	Diabetes	30	3	—	2
12.	Vascular Lesions of Nervous System ...	497	17	11	27
13.	Coronary Disease, Angina	578	17	24	31
14.	Hypertension with Heart Disease	73	—	1	3
15.	Other Heart Disease	344	6	15	14
16.	Other Circulatory Disease	132	1	4	8
17.	Influenza	22	—	—	1
18.	Pneumonia	85	4	2	1
19.	Bronchitis	88	2	2	10
20.	Other Disease of the Respiratory System	31	1	—	2
21.	Ulcer of Stomach and Duodenum ...	22	1	2	—
22.	Gastritis, Enteritis and Diarrhoea ...	14	—	—	1
23.	Nephritis and Nephrosis	17	—	2	—
24.	Hyperplasia of Prostate	13	—	1	1
25.	Congenital Malformations	32	—	1	3
26.	Other Defined and Ill defined diseases ...	240	6	7	14
27.	Motor Vehicle accidents	40	3	—	1
28.	All other accidents	76	—	1	4
29.	Suicide	24	—	1	—
30.	Homicide and Operations of War ...	1	—	—	—

...MINISTRATIVE AREAS (1963)

...Whitehaven M.B.	Workington M.B.	Aggregate of U.D.'s	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D.'s.
80	353	1066	33	452	237	397	178	142	308	1747
1	—	2	—	—	—	2	—	—	1	3
—	—	—	—	—	1	—	—	—	—	1
—	—	1	—	—	—	—	—	—	1	1
—	—	—	—	—	—	1	1	—	1	3
5	9	23	—	10	5	22	3	5	4	49
12	13	37	1	15	10	13	10	3	9	61
3	5	14	—	8	3	3	2	3	3	22
—	1	3	1	3	1	4	1	—	3	13
28	21	82	3	27	14	38	18	6	24	130
1	1	5	1	—	—	—	2	—	1	4
4	2	11	1	2	3	6	1	2	4	19
44	65	197	10	78	45	54	36	26	51	300
49	75	216	6	89	52	79	35	38	63	362
8	9	24	—	14	8	11	4	—	12	49
29	45	133	3	79	33	18	7	29	42	211
11	12	42	—	16	7	34	11	6	16	90
—	5	6	—	4	2	5	—	1	4	16
8	13	30	1	24	6	11	5	1	7	55
12	8	39	2	11	7	20	4	1	4	49
5	2	10	—	3	2	5	3	4	4	21
4	3	11	—	2	2	4	2	—	1	11
1	2	4	—	3	1	2	—	3	1	10
1	1	4	—	3	—	1	4	2	3	13
—	1	5	—	2	—	4	—	—	2	8
5	4	14	1	4	5	4	2	1	1	18
37	36	103	3	31	16	34	19	2	32	137
4	3	13	—	7	4	6	1	5	4	27
7	10	27	—	13	7	12	6	3	8	49
1	7	10	—	4	3	4	1	—	2	14
—	—	—	—	—	—	—	—	1	—	1

BIRTH AND DEATH STATISTICS

Year	Estimated Mid-Year Population	Births		Deaths		Excess of Births over Deaths
		No.	Rate	No.	Rate	
1922 ...	218499	4863	22.3	3218	14.7	1645
1938 ...	194900	3092	15.9	2638	13.0	454
1947 ...	202460	4446	22.0	2788	13.8	1658
1951 ...	214700	3681	17.1	2827	13.2	854
1952 ...	215050	3714	17.3	2603	12.1	1111
1953 ...	216100	3608	16.7	2571	11.9	1037
1954 ...	216600	3533	16.4	2567	11.9	966
1955 ...	216700	3556	16.4	2653	12.2	903
1956 ...	217450	3679	16.9	2653	12.2	1026
1957 ...	217600	3901	17.9	2640	12.1	1261
1958 ...	217700	3834	17.6	2643	12.1	1191
1959 ...	218900	3888	17.8	2611	11.9	1277
1960 ...	219160	3940	18.0	2629	12.0	1311
1961 ...	221460	3900	17.6	2725	12.3	1175
1962 ...	223330	4085	18.3	2723	12.2	1362
1963 ...	224630	3964	17.7	2813	12.5	1151

POPULATION

During the latter part of the year an investigation has been carried out in the department on the County's population trends. The purpose of this has been two-fold, to plan health and welfare services for specific numbers of the elderly, with the numbers of the succeeding, and to some extent supporting, generation in mind; and secondly to compare the local figures with the average for England and Wales.

This latter has yielded some very interesting results. In the first place the County's population now — 224,630 — in spite of a possible natural increase of 48,000, is only some 4,000 more than it was 40 years ago. Taking figures from 1920, the actual population is 37,500 less than it could have been from natural increase alone, even discounting possible increase from those who have left.

The main cause is immediately apparent. In the period 1925 to 1938 the population decreased by some 26,000 (see figure 1), and this lasting migratory effect of the depression, particularly in the industrial area of West Cumberland, can be seen in figures 2 and 3 where the population at the 1961 census in the 50—59 age group was 1.1% below the national average. This factor must surely lead to an increased load for the health and welfare services in the County. The other very noticeable variation is in the two younger age groups, where the total of those aged 0—19 is 2.3% above the national average. This makes the age distribution of the County younger than that of England and Wales as a whole.

Figure 4 shows the migratory effect of the depression at the time of the 1931 census, large numbers of young people in the 20—40 group, having left the County to give a figure of 2.1% below the national average. The 1931 census report on the County comments that the balance of migration had been outward in nearly every county district, the loss ranging up to 26.5% in one area of West Cumberland. By the 1951 census, this group (figure 6) was 20 years older and the greatest deficit was in the 40—50 group, although there had been a partial recovery to give a figure of 1.2% below the national, a level which has been maintained since.

Figure 1.

CUMBERLAND

Year	Population	Excess of Births Over Deaths	+/— Populatio
1920 ...	214,214	2865	—
1921 ...	216,691	2622	+2477
1922 ...	218,499	1645	+1808
1923 ...	219,720	1854	+1221
1924 ...	221,010	1621	+1290
1925 ...	220,030	1216	— 980
1926 ...	217,400	1584	—2630
1927 ...	216,230	761	—1170
1928 ...	210,600	1185	—5630
1929 ...	208,720	824	—1880
1930 ...	208,720	1059	—
1931 ...	205,270	776	—3450
1932 ...	205,550	640	+ 280
1933 ...	204,010	417	—1540
1934 ...	202,400	570	—1610
1935 ...	201,000	647	—1400
1936 ...	199,590	591	—1410
1937 ...	196,080	325	—3510
1938 ...	194,900	454	—1180
1939 ...	198,940	418	+4040
1940 ...	209,930	84	+10990
1941 ...	216,130	737	+6200

Figure 1.

CUMBERLAND

Year		Population	Excess of Births Over Deaths	+/— Population
1942	...	211,030	973	—5100
1943	...	206,230	1033	—4800
1944	...	198,780	1473	—7450
1945	...	195,120	1037	—3660
1946	...	200,660	1389	**+5540**
1947	...	202,460	1658	**+1800**
1948	...	210,020	1631	**+7560**
1949	...	212,170	1209	**+2150**
1950	...	215,900	1090	**+3730**
1951	...	214,700	854	—1200
1952	...	215,050	1111	**+350**
1953	...	216,100	1037	**+1050**
1954	...	216,600	966	**+500**
1955	...	216,700	908	**+100**
1956	...	217,450	1026	**+750**
1957	...	217,600	1261	**+150**
1958	...	217,700	1191	**+100**
1959	...	218,900	1277	**+1200**
1960	...	219,160	1311	**+260**
1961	...	221,460	1175	**+2300**
1962	...	223,330	1362	**+1870**
1963	...	224,630	1151	**+1300**

Fig.

POPULATION AGE GROUP VARIATION ON THE NATIONAL NORM.

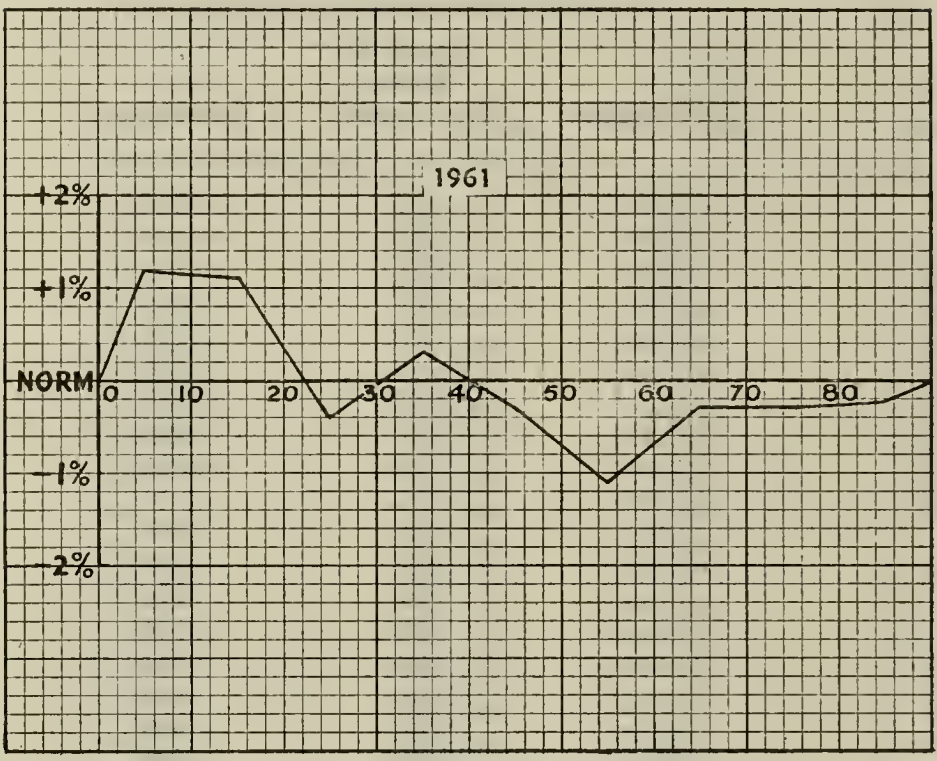
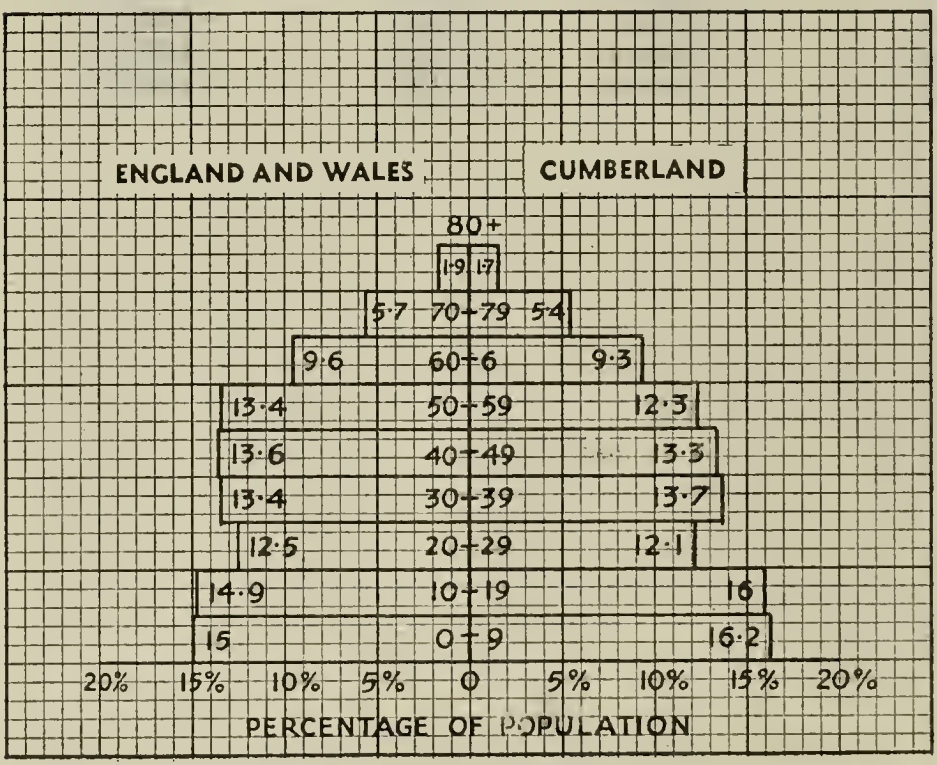


Fig.

POPULATION AGE GROUPS—1961



CUMBERLAND

Fig. 4

POPULATION AGE GROUP VARIATION ON THE NATIONAL NORM.

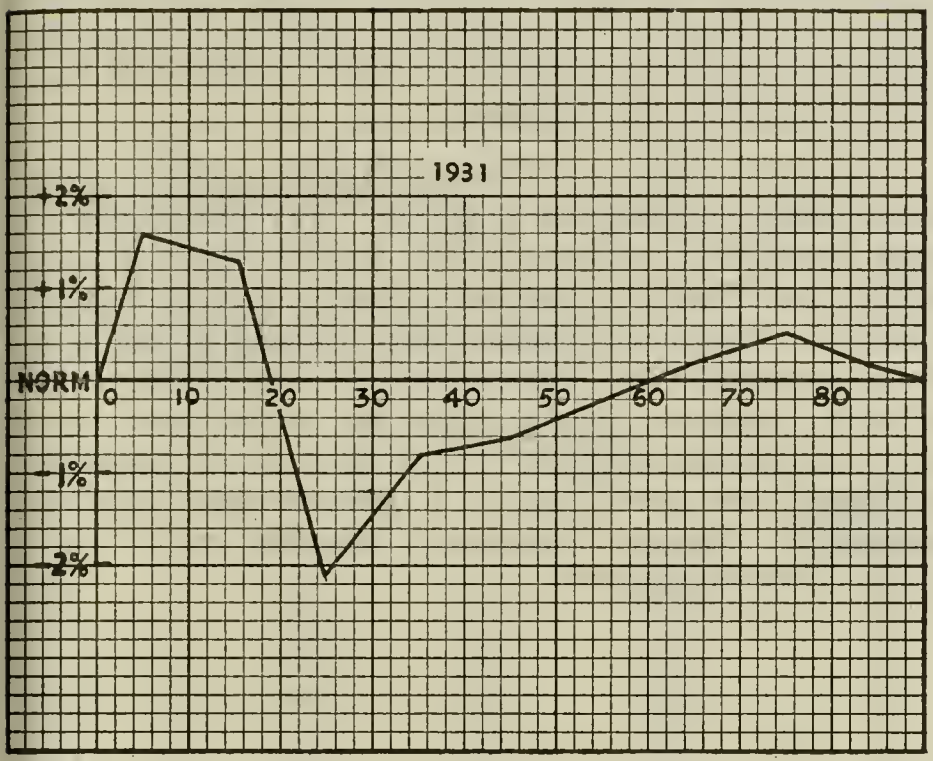
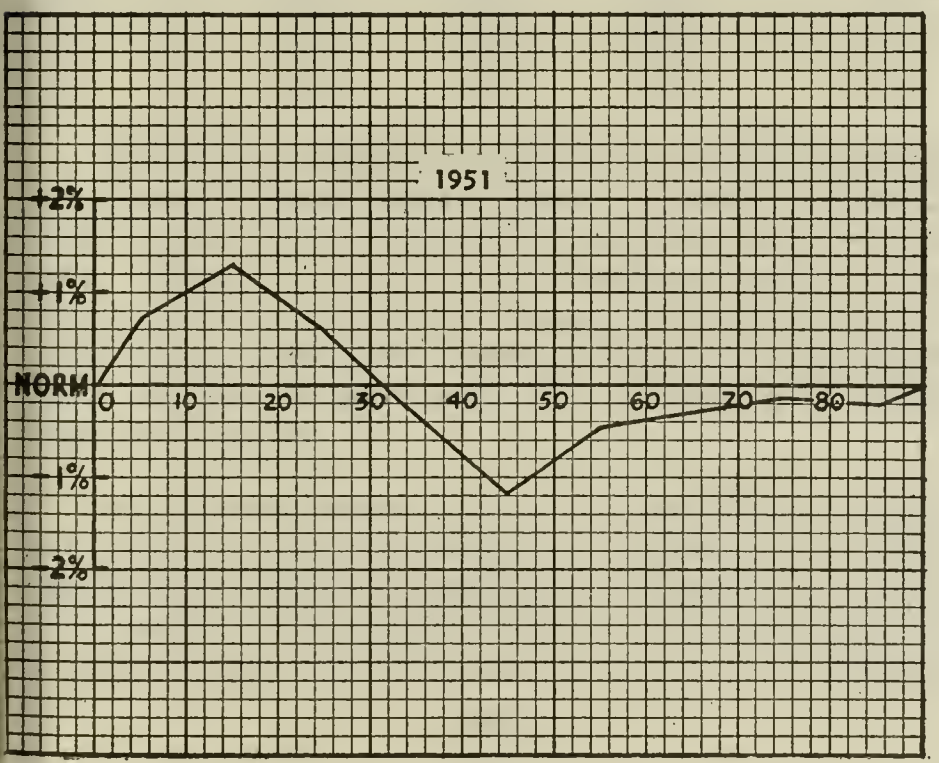


Fig. 5



More recently, over the last 10 years, the population has increased by 7,230, while the excess of births over deaths has been 11,514, showing an average emigration rate of 300 to 350 per year. A closer examination of the figures does, however, show that the County has held its natural increase in two of the last three years with welcome net inward migration.

Finally, it is interesting to compare today's population figures to the economic circumstances of the area. As I have pointed out in my preface to this Report, there is outward migration in the northern part of West Cumberland, an area of static or declining employment; while in the southern part, a brighter picture of increasing employment for males, has lead to a high natural increase and inward migration. In the eastern part of the County when factors such as the construction of the rocket site at Spadeadam are isolated, the general tone of a predominantly agricultural community is seen, with a sound level of natural increase but a balance of outward migration.

MIDWIFERY SERVICE

The main trends in the midwifery service have caused some concern throughout the year and many meetings and discussions have taken place in an effort to form a clear policy for the future. During the year 141 midwives notified their intention to practice. These include 7 whole-time midwives, 79 district nurse midwives working in urban and rural areas and 55 midwives working in the maternity department of hospitals in the administrative county. For a number of years there has been a steady decline in the number of domiciliary confinements attended by midwives. The following table illustrates this trend over the past ten years.

Live and Still Births

Year		Domiciliary	Institutional	Total	% Institutional Confinements
1954	...	1482	2112	3594	59
1955	...	1488	2167	3655	59
1956	...	1584	2257	3841	59
1957	...	1473	2556	4029	63
1958	...	1413	2473	3886	64
1959	...	1323	2674	3997	67
1960	...	1225	2821	4046	70
1961	...	1128	2809	3937	71
1962	...	1148	2988	4136	72
1963	...	982	3015	3997	75

Some of the problems associated with the declining domiciliary birth rate in the county were mentioned in my report last year. In 1963 there has been a further 3% increase of institutional confinements resulting in only 982 home confinements, which was less than 1,000 for the first time in the history of the midwifery service. Visits paid to these patients totalled 10,871, and a further 3,096 visits were paid to mothers who were discharged from hospital before the tenth day.

An immediate problem due to this trend is that of the midwife losing her skills and consequently her efficiency. To maintain efficiency I think it is necessary for a midwife to be in charge of at least 12 to 15 confinements a year. The seriousness of the position is clearly seen when a study is made of the confinements

attended during 1963. Forty of the 65 district nurse/midwives attended ten or less deliveries during the year, and 22 in fact had five or less confinements.

No. of deliveries	0-5	6-10	11-15	16-20	21-25	26-30	31-35
District Nurse/ Midwife or District Nurse/ Midwife/Health Visitor	22	18	9	8	1	3	4

With the opening of the maternity unit at the new West Cumberland Hospital at Hensingham, there will be further maternity beds available in West Cumberland in 1964 and it is probable that the number of domiciliary births will eventually decrease to 600 a year when this unit is fully operative.

A further problem created by the declining domiciliary birth rate is the provision of sufficient midwifery cases to meet the requirements of the Central Midwives' Board for nurses engaged on their Part II Midwifery Training. The Part II Midwifery Training course extends over a period of six months, three months training to be done in hospital and the remaining three months being spent on the district. Whilst on the district the pupil must attend at least ten home confinements.

It is very probable that the Central Midwives' Board will be considering changes in the midwifery training and it may be that before long new regulations will reduce the number of cases a pupil midwife must take on the district.

At the moment there are just enough domiciliary cases for the continued training of pupils, but with the increase in institutional births in West Cumberland following the opening of the new maternity unit at the West Cumberland Hospital, the position will have to be closely watched.

Several meetings have been held throughout the year with all parties concerned with the problem and different solutions have been examined, but in each case further complications have arisen.

As a result of this situation misgivings have been expressed by the midwives on various aspects of the service. The major causes of concern both to myself and the midwives are:—

(a) The midwife feels she is losing her skills and efficiency.

(b) Frustration at not being allowed to do the work for which she is trained.

(c) Although domiciliary confinements are decreasing, the selection of cases for hospital still leaves much to be desired. Normal cases carrying no obvious obstetric or medical risk are being recommended for hospital and high risk cases are still having confinements at home.

These problems are not easy to solve but three approaches might be made:—

(a) Increasing areas of domiciliary midwifery practice to achieve a minimum of 12—15 cases per year.

(b) The possibility in future of domiciliary midwives working in General Practitioner Obstetric units. This is only possible at present in emergency as happened during the year when a district nurse/midwife was called upon to help at a local general practitioner obstetric unit during a temporary shortage of staff.

(c) The introduction of radio telephony in midwives' cars to facilitate communications in view of greater distances to be covered.

The very desirable possibility of seconding domiciliary midwives to group practices as has developed well already regarding health visitors and certain district nurses, has also been rendered more remote; though I am glad to say that by now in two areas, viz. Penrith and Millom, a certain amount has been achieved in this direction in the secondment of district nurse/midwives to practices.

The overall situation is assuming grave proportions and although every effort will be made in the coming months to alleviate it, I think the time has come for guidance and support to be given centrally by the Ministry of Health.

Of major assistance would be the maximum retention of general practitioner obstetric units and approval for further joint use of midwives in these units and in domiciliary work.

Ante-Natal Work and Mothercraft Classes

The ante-natal work continues to be a most important and interesting part of the midwives' work; it is so obvious that many complications can be prevented by good ante-natal care. Advice given by the midwife to an expectant mother at the most vital time in her life can do an immense amount of good and save the mother much anxiety. Unfortunately, there are still a few who do not seek the midwife's advice and for reasons best known to themselves evade the advice and help which is available to all. This may result in an emergency call when the life of the mother or baby is endangered, and is something which could be prevented by seeking advice from either the doctor or midwife in the early stages of pregnancy.

Ante-natal clinics are held throughout the county in the County Council clinics and in the doctors' and district nurses' surgeries. 929 expectant mothers attended during the year and in addition the midwives paid 10,922 visits to expectant mothers in their own homes. Three hundred mothers attended for post-natal examination either at the doctors' surgeries or the county clinics.

The demand for mothercraft and relaxation classes is increasing, by both hospital and domiciliary booked expectant mothers joining in the same class. These, with the exception of Alston, are held in the county clinics, i.e. at Aspatria, Brampton, Egremont, Frizington, Keswick, Maryport, Millom, Penrith, Seascale, Whitehaven and Workington. The programme covers ten sessions and both midwives and health visitors combine to make it a comprehensive and interesting course. During the year 316 classes were held and 391 mothers attended, the total attendances being 1,411. It must be remembered that at the same time maternity units are

also holding classes and a considerable amount of individual tuition is given in the patient's own home, particularly in the rural areas where it is not possible for a mother to attend a class owing to the distance involved, inability to leave the children, or in some cases because she is herself out at work.

Part II Midwifery Training in co-operation with Workington Infirmary Maternity Unit has continued successfully throughout the year. Seven pupils completed the course and all were successful in passing the Part II examination of the Central Midwives' Board. Reference has already been made to the likelihood of there being insufficient domiciliary cases for this training to continue. I feel this would be a retrograde step since the training of midwives adds a stimulus to the work of the district midwives, who are extremely interested in the work.

Medical help was sought by the midwives according to the rules of the Central Midwives' Board on 134 occasions, as set out in the following table.

Table B

Ante-natal Period—	
Antepartum haemorrhage	4
Hypertension, albuminuria, etc.	10
Threatened or complete abortion	1
Early rupture of membranes	4
Multiple pregnancy	2
Miscellaneous	4
	25
During Labour—	
Premature labour	8
Delayed labour during 1st or 2nd stage	10
Retained placenta and P.P.H.	8
Breech presenting	2
Ante-partum haemorrhage	7
Ruptured perineum	32
Foetal distress	10
White asphyxia—baby	1
Blue asphyxia—baby	5
	83

During Puerperium—

Mother—

Pyrexia	6
Phlebitis	3
Appendicitis	1

Baby—

Discharging eyes, spots, vomiting	14
Jaundice	1
Premature baby	1
	26

During the year, 156 patients who were booked for home confinement later required admission to hospital, and details of the causes of the change in place of confinement are shown in table 'C'.

Table C

Ante-natal period—

Toxaemia of pregnancy	21
Premature labour	20
A.P.H.	18
Post Maturity	12
Rh. Negative	3
Anaemia	3
Contracted pelvis	4
Early rupture of membranes	6
High parity (returned home within 48 hours) ...	2
Query multiple pregnancy	3
Malpresentation	4
Chest Conditions	1
Miscarriage	2
Unsuitable home conditions	5
Any other reasons	1

Complications of labour—

Delayed labour	17
Retained placenta	10
P.P.H.	1
Foetal Distress	—
Any other reasons	13

Post-natal—

Condition of mother	3
Condition of baby	7
	156

Of this number. 48 cases were high risk patients in that they had had three or more pregnancies in the past, or had an obstetric or medical history which would normally dictate hospital confinement. These cases are, of course, a special source of anxiety and a heavy responsibility lies on both the domiciliary midwife and family doctor to do their utmost to persuade these mothers that their confinement should be planned for hospital. In all of these cases mentioned, considerable work was in fact put in on the mother but she was unwilling to change her mind.

Of the total 156 patients shown in table 'C', 68 were in fact admitted to hospital in the ante-natal period, 81 during labour, and 7 during the puerperium, involving 15 stillbirths, 7 neonatal deaths and 2 miscarriages.

The standard co-operation record card for maternity patients has been adopted for use in East Cumberland but not yet for West Cumberland. It does not appear to be universally acceptable but when used, the midwives have found it most helpful. There have been no reactions from the mothers indicating any anxiety about information on the card.

Local Maternity Liaison Committee

The Maternity Liaison Committees have continued their meetings throughout the year and have met three times in West Cumberland and four in East Cumberland.

Many items affecting the midwifery service have been considered. The change in the ratio of hospital and domiciliary confinements which is well above the limit 70/30 as envisaged by the Cranbrook Report has caused much discussion by both Committees. At the end of the year the ratio was 76/24 for West Cumberland and 75/25 in East Cumberland. This is likely to change even further when the new maternity unit in the West Cumberland Hospital opens early in 1964.

Another subject for discussion was the admission of all 'high risk' cases to hospital. This has an obvious bearing on the stillbirth and perinatal death rate.

The Ministry of Health standard co-operation card was fully considered in both East and West Cumberland but it was not universally accepted and finally it was decided to use it only in the East of the county. The others prefer a card already in use which is not held by the patient, thus substantially differing from the object of the co-operation card.

A standard and more convenient form of equipment for blood sampling was considered by the East Cumberland Committee and an arrangement has now been established whereby a pack is supplied by the hospital laboratory for ante-natal blood sampling in domiciliary confinements. The local authorities contribute the pre-sterilised disposable syringes which these contain.

Three monthly statistics of stillbirth and perinatal mortality rates are available at each meeting and are fully discussed. This is valuable to all members of the Committee as it consolidates the work and stimulates discussion on the various problems revealed by the figures. As mentioned elsewhere in this report, a study has now been begun for 1964 of all perinatal deaths occurring in the East Cumberland area.

The free exchange of views between all members of the Committee, who welcome the opportunity to meet together, has been most beneficial to all concerned and strengthens the feeling that all are involved in patient care, whether working in hospital or in the domiciliary field.

Analgesia for Home Confinements

The full time midwives and district nurse/midwives undertaking more than 25 cases per year are provided with both Trilene and Gas and Air machines. Other midwives with a smaller number of cases have only the Gas and Air apparatus. This year Trilene has been administered in 357 cases and Gas and Air in 475, making a total of 832.

New legislation at present under discussion regarding the future use of the Gas and Air machine, will no doubt be in operation before long.

Postgraduate Courses

The Superintendent Nursing Officer attended a refresher course for Supervisors of Midwives held in London, and twelve midwives attended courses at Bangor, Birmingham, Hull, Newcastle and Leeds, according to the instruction in Rule G. of the Central Midwives' Board. These courses are most helpful and instructive and the midwives are brought up to date with the latest trends in their work.

Each year the local branches of the Royal College of Midwives hold study weekends in both East and West Cumberland. The local consultant obstetricians and physicians give of their valuable time and knowledge to further the endeavours of the midwives. This co-operation is much valued and appreciated.

Notification of Congenital Malformations

A memorandum issued by the Ministry of Health in November 1963 asked all Medical Officers of Health to arrange for a record to be kept as from 1st January, 1964 of all congenital malformations apparent at birth, and for classified information on each child whether a live or stillbirth to be sent to the Registrar General by the first day of the second month following that in which the birth occurred. All the midwives are co-operating with general practitioners in this exercise.

Maternity Outfits

Under the National Health Service Act, 1946, Maternity Outfits are supplied by the County Council, without charge, to domiciliary confinement cases. Outfits are delivered by the manufacturers to Clinics and stocks are also held in the County Health Department and the Area Office at Whitehaven. The content of the packs is constantly under review in order that the equipment should be the most suitable and best available.

CARE OF MOTHERS AND YOUNG CHILDREN

Perinatal Mortality

The perinatal mortality rate — the number of stillbirths and first week infant deaths per 1,000 live and stillbirths — has, I am glad to say, been further reduced in Cumberland in 1963 to a figure of 33.7. I believe there are grounds now to hope for a more consistent improvement in this highly important figure such as has been apparent in the national figure for some years. See table page 50. The national figure for 1963 will doubtless be under 30 for the first time.

In May of 1963 I considered this matter of sufficient importance to submit a memorandum on the subject to the Health Committe with a view to furthering necessary contacts with the hospital authorities on the proper selection of cases for both hospital and home confinement. The cardinal importance of this issue I have repeatedly stressed and I believe some progress has been made here.

The perinatal mortality rate continues to be quite significantly higher in East Cumberland than in the West. Partly at least with a view to elucidating this difference, the East Cumberland Local Maternity Liaison Committee has decided to study in further detail all perinatal deaths occurring in that area, with general practitioners, hospital staffs and local authority midwives co-operating in collating the data on each case. Another point of welcome significance for East Cumberland in respect especially of early neo-natal care is the decision to appoint a consultant paediatrician to the East Cumberland Hospital Management Committee in 1964 or 1965.

Towards the end of 1963 there was published a final and complete report of the British Perinatal Mortality Study conducted in 1958 under the auspices of the National Birthday Trust Fund. All areas of the country co-operated to study in great detail all perinatal deaths occurring in one week in March of that year. Although various aspects of the research have been reported on successively since it was carried out, the very fact that only towards the end of 1963 was the final report published emphasises how far

reaching and extensive can be the significance of such a study. The results leave no doubt as to the vital importance of those aspects of ante-natal care, including careful selection of place of confinement, which I have repeatedly stressed in annual and other reports to committees.

With regard to the causes of perinatal and infant deaths shown in the above tables, there is no striking change in the relative prominence of any particular cause, although prematurity and congenital malformations continue to play a leading role. It has also to be remembered in studying these causes, that many of the deaths are the result of multiple factors which cannot be shown clearly in tabular form. For example it will be seen that there are 3 deaths from meningitis of infants of one week or over. Although this was given as the primary cause of death all were associated with congenital malformation of the central nerve system.

Year	Stillbirths	Early Neonatal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal Deaths per 1,000 total births	
				Cumberland	E'land & Wales	Cumberland	E'land & Wales
1953 ...	99	54	153	27.0	22.4	41.3	37.0
1954 ...	106	53	159	29.8	23.5	43.7	38.1
1955 ...	79	61	140	21.7	23.2	38.5	37.6
1956 ...	111	64	175	29.3	23.0	46.2	36.8
1957 ...	102	64	166	25.5	22.4	41.5	36.2
1958 ...	80	69	149	20.4	21.6	38.1	35.1
1959 ...	83	54	137	20.9	20.7	34.5	34.2
1960 ...	111	60	171	27.4	19.7	42.2	32.9
1961 ...	76	53	129	19.3	18.7	32.4	32.2
1962 ...	78	71	149	18.7	18.1	35.8	30.8
1963 ...	76	60	136	18.8	17.3	33.7	—

Analysis of Causes of 136 Perinatal Deaths during 1963

Cause of Death	Stillbirths		Deaths during	
	Premature	Full-time	1st Week	Total
Toxaemia	6	1	—	7
Antepartum Haemorrhage ...	6	2	—	8
Placental Insufficiency	3	4	—	7
Rh. with Antibodies	4	1	3	8
Prematurity	—	—	22	22
Congenital Malformation ...	9	4	4	17
Asphyxia—	—	—	5	5
(1) Prolapse of Cord	1	1	—	2
(2) Cord around neck	2	5	—	7
(3) Intra Uterine	1	11	—	12
Difficult labour	—	1	—	1
Atalectasis	3	2	8	13
Congenital heart disease	—	—	2	2
Cerebral Haemorrhage	1	2	9	12
Prem. Separation of Placenta ...	1	—	—	1
Toxic Hepatitis	—	—	1	1
Adrenal genital syndrome ...	1	—	—	1
Bilateral pleural effusion	—	—	1	1
Congenital cystic lung	—	—	1	1
No known cause	3	1	4	8
	41	35	60	136

Infant Mortality

Cause of Death	Age in Weeks Under 1	1 to 4	4 to 52	Total
Rh. with Antibodies	3	—	—	3
Prematurity	22	2	—	24
Congenital Malformations ...	4	2	—	6
Asphyxia	5	—	—	5
Asphyxia due to inhalation of vomit	—	2	1	3
Atalectasis	8	—	—	8
Pneumonia and Bronchitis ...	1	3	5	9
Bronchiolitis	—	—	1	1
Congenital heart disease	2	3	3	8
Cerebral Haemorrhage	9	—	—	9
Toxic Hepatitis	1	—	—	1
Bilateral pleural effusion	1	—	—	1
Congenital cystic lung	1	—	—	1
Meningitis	—	1	2	3
Gastro Enteritis	—	—	1	1
Pyroic Stenosis	—	—	1	1
Other Causes	3	—	—	3
	60	13	14	87

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales are as follows for the period 1953-63:—

Year	Rates per 1,000 total live births Cumberland	England and Wales
1953 ...	27	26.8
1954 ...	27.6	25.4
1955 ...	28.4	24.9
1956 ...	30.4	23.7
1957 ...	26.4	23.1
1958 ...	28.2	22.5
1959 ...	21.1	22.2
1960 ...	23.1	21.7
1961 ...	22.6	21.6
1962 ...	26.4	21.4
1963 ...	22.0	20.9

Prematurity

It is of interest to note that the percentage premature live births of total live births has decreased from 6.0% in 1962 to 5.9% in 1963.

Premature births notified during 1963 are set out below with the 1962 figures for comparison.

1. Number of premature live births notified—

	1962	*1963*
(a) In hospital	202	199
(b) At home	44	33
(c) In private nursing homes ...	1	—
Total ...	247	232

2. Number of premature stillbirths notified —

(a) In Hospital	37	28
(b) At home	6	3
(c) In private nursing home ...	1	—
Total ...	44	31

There was a total of 26 premature babies born at home; only one infant died giving a survival percentage of 96%. It should be noted that there were no premature babies born at home in the very low birth weight groups. The percentage in survival rate for home births shows no change from last year, while the percentage rate of hospital survival shows an increase of 3%.

Unmarried Mothers

The arrangements are unchanged for the admission of unmarried mothers to residential accommodation at Coledale Hall, Carlisle, St. Monica and Brettargh Holt at Kendal and the Salvation Army Home, "Hopedene", Newcastle. Annual grants continue to be paid to the Carlisle Diocesan Council for Social and Moral Welfare and the Lancaster Diocesan Protection and Rescue Society

During the year 31 cases were approved for maintenance. The average length of stay after confinement at Coledale Hall was 27 days, St. Monica 45 days, Brettargh Holt 49 days and other establishments 45 days. In the case of young mothers aged 16 or less it is sometimes desirable to make arrangements for an earlier than usual admission to a home and in such cases the length of stay can be extended according to the particular need.

The age groups of the 31 cases are shown in the following table with comparable figures for previous years. It will be seen that the number of unmarried mothers for whom accommodation has been provided has varied between 28 and 44.

Age		1963	1962	1961	1960	1959	1958	1957
13	...	1	—	—	1	—	—	—
14	...	1	2	—	—	—	—	1
15	...	3	3	1	1	1	—	—
16	...	—	5	3	3	3	1	1
17	...	2	4	5	3	4	2	3
18	...	3	7	2	3	6	5	5
19—24	...	12	12	22	20	16	15	15
25—30	...	7	4	1	10	5	5	9
31 and over	...	2	1	1	3	2	—	4
Totals	...	31	38	35	44	37	28	38

Commenting on her work with unmarried mothers during the year, Miss J. C. Pochin, Social Welfare Worker with the West Cumberland Welfare Association writes as follows: "My own records do not show a marked increase in very young girls who have become pregnant. In 1963 my clients included 2 unmarried mothers aged 15 and 1 aged 16, as against 2 aged 14, 3 aged 15 and 4 aged 16 in 1962.

A tendency which I did note in 1963 and which still continues is that more expectant unmarried mothers have chosen to be confined in hospital locally and have their babies cared for by foster parents pending placing for adoption, rather than enter a mother and baby home or maternity home. Hence I was sometimes hard put to, to find suitable foster mothers. This trend, if it is also occurring elsewhere, may account to some extent for the decline in the number of unmarried mothers for whom accommodation was provided. The desirability of choosing confinement in a local hospital is a matter for debate, but in most instances there was some good reasons for it, such as the presence of other young children at home."

At one of the main Homes where Cumberland mothers stay the tendency mentioned by Miss Pochin appears to be substantiated when comparison is made of the admissions for 1962 and 1963. In 1962 there were 79 admissions to the Home including 20 from Cumberland, whilst in 1963 there were 67 admissions which included only 9 from this area.

Premature Live Births

Weight at Birth	Born in hospital				Born at home or in nursing home								Premature Stillbirths	
		Died			Nursed entirely at home or in nursing home	Died			Transferred to Hospital on or before 28th day	Died				
	Total births	Within 24 hours of birth	In 1 day and under 7 days	In 7 days and under 28 days	Total births	Within 24 hours of birth	In 1 day and under 7 days	In 7 days and under 28 days	Total births	Within 24 hours of birth	In 1 day and under 7 days	In 7 days and under 28 days	Born	
													In hospital	At home or in a Nursing Home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lb. 3 oz. or less ...	11	8	3	—	—	—	—	—	1	1	—	—	5	—
2. Over 2 lbs. 3 oz. up to and including 3 lb. 4 oz.	14	7	2	—	—	—	—	—	—	—	—	—	5	3
3. Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. ...	42	5	2	1	5	—	—	—	—	—	—	—	10	—
4. Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. ...	53	1	6	2	2	—		—	3	—	1	—	2	—
5. Over 4 lb. 15 oz. up to and including 5 lb. 8 oz.	79	2	2	1	19	1	—	—	3	—	—	—	6	—
6. Total	199	23	15	4	26	1	—	—	7	1	1	—	28	3

Distribution of Welfare Foods

At the request of the Ministry of Health the County Council continues to arrange for the distribution of Welfare Foods to expectant and nursing mothers and children under five years of age.

The arrangements for distribution from Child Welfare Centres, the retail trade and private households have continued throughout the year. Members of the W.V.S. co-operate in the distribution to the various points and in the majority of cases are also concerned in the selling of commodities. All the W.V.S. members who are assisting with the distribution find that the Scheme is working quite smoothly, and are perfectly happy with the present arrangements. The help given by this voluntary organisation has again been extremely reliable and valuable. During the severe winter of 1962/63 many hazardous journeys were undertaken to get the foods through to the points, and on two occasion the snow plough came to the rescue. At the 31st December, 1963, there were 102 points in the County, of which 11 were Child Welfare Centres. In the towns, because of bigger demand, arrangements for the selling of welfare foods are made with local tradesmen. This ensures that the foods are available for sale daily and also eliminates storage difficulties which would arise if sales were arranged from a child welfare centre.

The following table shows the quantities of Welfare Foods issued to beneficiaries since 1955. In the last five years the sale of National Dried Milk has gone down by 26%, while Cod Liver Oil has gone down by 66% and Orange Juice by 62%. During the same period the birth rate has fluctuated between 18.3 and 17.4 although the rate in 1959 was higher than the rate for this year.

Total issues to beneficiaries and hospitals

Year	National Dried Milk (tins)	Cod Liver Oil (bottles)	Vitamin Tablets (packets)	Orange Juice (bottles)
1955 ...	145696	25082	6413	113548
1956 ...	151101	23669	7274	124212
1957 ...	128219	22517	6920	137336
1958 ...	115685	15198	6338	89366
1959 ...	105984	15350	7076	93684
1960 ...	92676	14961	7475	90343
1961 ...	78155	9067	5017	50653
1962 ...	79446	4712	2669	31964
1963 ...	78858	5162	2630	34973

Dental Service

The Chief Dental Officer, Mr. R. B. Neal, makes the following comments on the Dental Services for 1963:—

The year 1963 has seen the beginning of re-equipment of dental surgeries in Cumberland. The main surgery at Carlisle has been completely altered and, besides having a recovery room made, all the most modern equipment has been installed. This includes the McMaster "Slave" unit which is the most advanced unit available and enables the operator to work whilst comfortably seated.

A new clinic was opened at Seascale during the year and the dental surgery suite is the prototype for future part-time clinics. The equipment in this clinic is excellent and includes an air turbine, but has not got a unit installed. This clinic provides excellent facilities in a part of the county which has tended to be rather neglected due to its geographical position and it is most gratifying to see the increased demand for dental treatment from maternity and child welfare patients.

Reference should be made to the close relationship between the hospital services and those provided by the County. X-Ray facilities are provided at Whitehaven Hospital and patients requiring multiple extractions, or those requiring a general anaesthetic but who are not suitable to be done in a clinic because of some medical condition, are admitted to one of the hospitals for treatment. It is most satisfying to know that one of our dental officers will shortly be attending to patients in two geriatric hospitals, which will supply a long needed want.

There has been a slight decrease of work done during the year. This was due to the unusual amount of sickness which affected the staff—one dental officer being off for three months.

During the year 1964 one more new clinic is to be opened at Salterbeck, Workington, and two of the older ones will be modernised. All are being equipped with the McMaster "Slave" unit, which has proved so successful in Carlisle.

One matter which is causing marked concern to the dental staff is the amount of dental decay apparently being caused by mothers giving their infants, in all good faith, vitamin syrups of fruit squashes. These syrups all contain a high percentage of sugar and are all fairly acid, thus producing perfect conditions in the mouth for the bacteria responsible for decalcification of enamel and the further break down of the teeth, to do irreparable damage.

It is most encouraging to see that the number of pre-school children attending the clinics has increased over the past year, but there has been a slight fall off in the demand for dental treatment by expectant and nursing mothers due, no doubt, to the service provided by the general dental practitioners. Most parts of Cumberland have an adequate number of private dentists, but there are a few areas where the local authority services are the only means of providing dental treatment unless the patients travel a long way.

It is with regret that one has to record the resignation of Mr. Macdonald, who left Cumberland to take up an appointment in East Africa, but we are fortunate in having appointed Mr. Martin Green, a London graduate, to succeed.

Child Welfare Centres

Child welfare centres are provided by the County Council in 29 situations in the county, and the table which follows shows the remarkable increase in attendances over the last ten years. Attendances in 1963 numbered 31,948, compared with 12,794 in 1954, an increase of 150%.

The increase is most marked over the last two years, this year's figure being 17% higher than that for 1962 and 39% higher than in 1961.

The new building at Seascale, where a clinic and library are provided together, opened in May and has proved most successful. The facilities provided impressed the local residents so much that they asked their parish council to convey their gratitude to the County Council. In addition, a new centre was commenced at Dalston, five miles from Carlisle, and this completed the provision

of clinics for villages on the periphery of Carlisle. A new clinic is at present being built at Salterbeck, Workington, to replace unsatisfactory rented premises at Harrington and Westfield, and this should be ready for use in the spring of 1964.

Much emphasis is being placed at the moment on more effective co-operation between general practitioners and local authority health departments, and indeed this was one of the main recommendations of the Gillie Report. To encourage this trend in Cumberland a scheme was approved by the authority during the year for the employment of family doctors in County Council clinics on a sessional basis. Unfortunately, mainly because of problems of a national character the scheme proved unacceptable to the general practitioners as a whole and cannot go forward at present. However, I feel that once difficulties are ironed out nationally, any local difficulties could soon be settled and that the scheme could become operative in the near future.

I am happy to report one trend in the same field which is a logical extension of the concept of health visitor secondment. Under this arrangement child welfare sessions are held in certain general practitioners' surgeries with the health visitor in attendance. The services available at the surgeries in most cases include immunisation as well as child welfare, and with the health visitor in attendance proper attention can also be given to health education and family social problems. Since the inauguration of the scheme in August there have been 129 sessions and attendances have numbered 1,477.

The ten year plan envisages the provision of ten new clinics. Eight of these clinics will replace unsatisfactory premises at present in use and new clinics at Tarraby, near Carlisle, and Moorclose, Workington, will provide a service for developing communities.

Voluntary workers have given assistance at 23 of the child welfare centres and I hope eventually that this assistance will be made available at all of the major centres. The health visitors are most appreciative of this assistance, and in my report on health visiting I have quoted the observations of a health visitor and a voluntary worker.

Attendances at Child Welfare Clinics (1954-63)

Year	No. of centres provided at end of year	No. of child welfare sessions held per month at centre	No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
			Under 1 year	1—2 years	2—5 years		
1954 ...	15	65	933	1027	1181	3141	12794
1955 ...	15	58	975	896	1103	1947	11734
1956 ...	15	59	1053	922	964	2939	11912
1957 ...	18	69	1310	1051	1056	3417	14452
1958 ...	19	88	1326	1192	1225	3743	18061
1959 ...	22	92	1596	1455	1389	4440	21947
1960 ...	22	95	1548	1408	1368	4299	22089
1961 ...	23	95	1603	1667	1704	4974	23004
1962 ...	27	96	1894	1625	2080	5599	27299
1963 ...	29	98	1901	1892	2007	5800	31948

Child Welfare Centres

The following table gives particulars of the sessions and attendances at Child Welfare Centres throughout the County:—

CHILD WELFARE CENTRES 1963

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Alston	Cottage Hospital, Alston	Wednesday	52	428	8
Anthorn	2 Fell View, Anthorn	2nd and 4th Thursday	14	298	21
Aspatria	North Road, Aspatria	Wednesday	52	937	18
Brampton	Union Lane, Brampton	Friday	46	1485	32
Cleator Moor	Jacktrees Road, Cleator Moor	Thursday	51	2150	42
Cockermouth	Harford House, Cockermouth	Monday	48	1281	27
Crosby, Maryport	Nurse's House, Parkside, Crosby	1st & 3rd Wednesday	10	66	7
Dalston	Village Hall, Dalston	2nd & 4th Monday	21	546	26
Egremont	St. Bridget's Lane, Egremont	Thursday	51	2796	55
Frizington	Council Chambers, Frizington	Monday	50	1347	27
Houghton	Village Hall, Houghton	2nd & 4th Wednesday	24	429	18
Keswick	13-15 Bank Street, Keswick	Thursday	51	816	16
Longtown	Esk Street, Longtown	Tuesday	35	1087	31
Longtown C.A.D.			25	320	13
Maryport	24 Selby Terr., Maryport	Tuesday	49	1231	25
Millom	18 St. George's Road, Millom	Tuesday	47	1259	27

Child Welfare Centres—Continued,

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Penrith	Brunswick Sq., Penrith	Tuesday	50	1470	29
Scotby	Village Hall, Scotby	1st & 3rd Thursday	24	305	13
Seascale	Gosforth Road, Seascale	Thursday	50	1256	25
Seaton	Miners' Welfare Hall, Seaton	Thursday	24	740	31
Thornhill	Community Centre, Thornhill	1st & 3rd Wednesday	24	641	27
Wetheral	Village Hall, Wetheral	2nd & 4th Thursday	24	277	12
WHITEHAVEN—					
Flatt Walks	Flatt Walks, Whitehaven	Tuesday	50	1908	38
Mirehouse	Dent Road, Mirehouse, Whitehaven	Tuesday	50	2010	40
Woodhouse	Woodhouse, Whitehaven	Wednesday	51	1848	36
Wigton	Birdcage Walk, Wigton	Monday	49	895	18
WORKINGTON—					
Park Lane	Park Lane, Workington	Wednesday	51	2005	40
Harrington	Methodist Hall, Harrington, Workington	Friday	51	1076	21
Westfield	St. Mary's Parish Hall, Moss Bay, Workington	Thursday	51	1050	21
		TOTALS	1175	31958	27
		AVERAGES	98 per month		

Family Planning Clinics

The present arrangements for advice on family planning are made through the Family Planning Association who hold sessions at the Park Lane Clinic, Workington, every Wednesday, and at the Brunswick Square Clinic, Penrith, where sessions are held twice monthly.

The number of patients seeking advice during the year was 808 at Workington and 138 at Penrith.

I am indebted to one of the doctors for the following observations of her work at one of the clinics:

"During the past year, most of the patients attending the clinics have again been women with one or more children wishing to plan or limit their families. Most of them have come direct to the clinic on recommendations by friends, health visitors, midwives, etc., or family doctors. A few have been referred by hospital consultants or general medical practitioners on medical grounds.

The small number of pre-marital patients, who are seen within six weeks of marriage, and the patients with marital difficulties, have been glad to avail themselves of appropriate literature.

The clinic is not yet prescribing oral contraceptives. There have been several enquiries about these and these patients have been interviewed and referred to their general practitioner or another clinic".

Nurseries and Child-Minders

The Nurseries and Child-Minders Regulation Act, 1948, places a duty on local health authorities to keep registers of, and impowers them to supervise:

(a) premises (i.e. day nurseries) in their areas, other than premises wholly or mainly used as private dwellings, where children are received to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days and

(b) persons (i.e. child-minders) in their areas who for reward receive into their homes children under the age of five to be looked after for the day or a substantial part thereof for any longer period not exceeding six days.

It is an offence under the Act for an occupier of premises to carry on a day nursery if the premises are not Registered or for an unregistered child-minder to receive into his home three or more children, of whom he is not a relative for more than one household.

At the end of the year there were seven persons Registered as child-minders for the care of 127 children.

In some cases these new registrations have been investigated by parents who have felt the need for the establishment of a pre-school play group so that they could leave their children somewhere safe and convenient whilst they did the morning shopping or visited a relative, etc. Another motive inspiring such groups is that mothers are seeking company for their children and in this role the child-minders are making a useful creative contribution.

Every effort is made to maintain high standards among child-minders and periodic inspections are made by members of the staff to ensure that the children receive the best care under pleasant and hygenic conditions.

Six of these premises were registered during the year and the following table shows the localities of these registrations together with the number of children provided for:—

East Cumberland	*West Cumberland*	*South Cumberland*
Brampton (12)	Cockermouth (30)	Seascale (10)
Kirkbampton (15)	Salterbeck (20)	
	Workington (30)	

The only other registration previous to 1963 which is still in force is Brampton — (10).

Marriage Guidance Councils

The County Council make grants to the two Marriage Guidance Councils operating in the area, the Carlisle, Cumberland and Eden Valley Marriage Council, established in 1961 and the Catholic Advisory Council established in 1962. Both Councils have their headquarters in Carlisle.

During 1963 the former applied for further assistance, to help provide a service in West Cumberland, and the Council has granted the free use of accommodation at Park Lane Clinic, Workington, for sessions to be held on two evenings each week.

The work of these Councils, reconciliation and education in marriage is unfortunately very necessary, when one considers that there are now about 31,000 divorces a year in England and Wales. Private interviews are given to those seeking help, and all counselling is undertaken in the strictest confidence. Each year about 14,000 couples seek help, and many marriages are thus saved from a breakup, which causes unnecessary suffering to children.

Below is a table of new cases dealt with by the two local organisations since their establishment.

	Carlisle, Cumberland & Eden Valley Council		Catholic Advisory Council	
Year	Carlisle Centre	Workington Centre	Carlisle Centre	Total
1961	49*	—	—	49
1962	57	—	*	57
1963	55	19*	18	92

* Part year.

The figure of 18 new cases for the Catholic Marriage Advisory Council covers the period from September 1962 to the 31st December, 1963, and involved a total of 128 interviews by councillors, priests, doctors and lawyers. In addition, this Council also organised three engaged couples courses with a total attendance of 48 persons. The Secretary comments "It is rather difficult to estimate the valuc and influence of the Centre at this juncture so comparatively shortly after its beginning, but the number of interviews granted to date, is some measure of the need for this work in the local catholic community whilst, of course, ever since the Centre was inaugurated it has been available to members of the public".

"There is no doubt that our work is increasingly appreciated by the clergy and welfare workers and it is felt that the pre-marriage talks form a particularly useful service. This is obvious from an analysis of the questionnaires which are completed by those attending".

"Finally, whilst we feel that the work which we have carried out to date has been of considerable social significance we seek other outlets for our energies, and very shortly hope to embark on programmes involving talks to schools and to groups of parents".

The Secretary of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council comments, "Each year has shown a steady growth in the number of couples seeking help. We now have three fully trained councillors and one in training, and need publicity to use these councillors more fully.

"During the last 18 months the educational side of the work has grown rapidly and would grow even more if we had the group leaders to deal with the requests we get to lead discussion groups and with youth clubs and young people about to leave school.

"The Council started work in West Cumberland last November and is most grateful to the Cumberland County Council for making this possible. This is a voluntary piece of social work, but the councillors and group leaders are carefully selected and trained by the National Marriage Guidance Council".

Child Welfare Survey

In my Annual Report for 1962 I gave details of the results of Part I of this survey, and during 1963, Part II was completed and Part III commenced. Part I was the interviewing of 500 mothers at random clinics by "neutral" W.V.S. interviewers. The mothers were asked why they came to the clinic, what were the main advantages and how the service could be improved.

Part II dealt with those mothers who lived within reasonable travelling distance of a clinic but who had not attended for some time. It was decided to write to all such mothers of children born between 1.7.60 and 3.6.61 who had not attended the clinic for at least 12 months. A prepaid envelope was enclosed and they were asked to reply giving the reason why they had stopped coming to the clinic. The names were obtained from the clinic registers and involved 727 mothers, 313 of whom replied as requested. This left 414 to be followed up by interview, and I am indebted to the local members of the Women's Voluntary Service who carried out this work, much of it during the severe winter conditions experienced in the early months of 1963. Eventually 392 of the 414 were interviewed and gave a reason or reasons why they had ceased to attend the clinic. The total replies were, therefore, 706 out of 717 a rate of 97%.

The replies were coded out into groups as follows: —

(A) —time factors;

(B) those intending to go again;

(C) those who had stopped after the child reached the age of 1 or 1½;

(D) those who only attended for immunisation and vaccination, etc;

(E) those who had had illness in the family or were now tied to their homes;

(F) those who the health visitor or district nurse visits regularly;

(G) no reason;

(H) those who had transport difficulties;

(J) those who were only concerned with baby's weight;

(K) those whose baby sleeps in the afternoon and who would attend a morning clinic;

(L) those who now go to their G.P.;

(M) those where the husband refuses to let the mother attend;

(N) those who consider themselves capable;

(O) those whose child did not like the clinic;

(P) those who did not like the clinic, the service or personnel;

(Q) those who only attended for welfare foods;

(R) those who did not like the other people attending the clinic.

These main headings were broken down into sub-headings for instance:—

A—Time Factors

1. Difficulty in attending because of large family (3—9 children).
2. Difficulty in attending because of husband's shift work.
3. Too busy—domestic affairs.
4. Time—takes too long to undress babies or too long to wait at clinic.
5. Mother working.
6. Clinic day inconvenient, e.g. (Monday—wash day).

L.—Those who now go to their G.P.

1. Prefers to go to G.P. with any problems
2. Injections given by appointment by G.P.
3. G.P. has a baby clinic.
4. Mother a G.P.

P.—Those who did not like the clinic.

1. No facilities at clinic for supervision of older children.
2. Clinic too hot.
3. Clinic too small—overcrowded.
4. Clinic staff not particularly interested or wrong attitude.
5. Clinic too cold.
6. Criticism of clinic M.O.

The group results were as follows:—

	Written Reply	%	W.V.S. Interview Reply	%	Total	%
A.	81	15	127	21	208	18
B.	60	11	42	7	102	9
B. (5) Left District	35	7	76	12.6	111	9
C. (3) will attend if necessary	23	4	14	2	37	3
D.	62	11	42	7	104	8
E.	28	5	30	5	58	5
F.	13	2	13	2	26	2
G.	5	1	9	1.5	14	1
H.	35	6	28	4.6	63	5
J.	47	8	29	4.8	76	7
K.	13	2	5	0.8	18	2
L.	43	8	58	9.6	101	9
M.	1	—	1	0.1	2	1
N.	12	2	10	1.7	22	2
O.	1	—	2	0.3	3	—
P.	22	4	26	4.3	48	4
Q.	7	1	4	0.7	11	1
R.	3	—	4	0.7	7	1
	557		605		1162	

It is interesting to see that the second highest group total percentage—C.—was for mothers who had stopped when their child had passed its first birthday or thereabouts. This was also the main reason for infrequent attendance in Part I.

The final, third stage of this survey is now well underway and is designed to obtain the attitude of a complete cross-section of the community towards child welfare clinics. This is a departure from the interviewing of the selected group most directly concerned with clinics. However, Child Welfare Clinics are for the benefit of the whole community; the general community attitude towards them reflects their value to some extent, and will need to be taken into consideration in future planning of the service.

The results of Part III will be in my Annual Report next year.

HEALTH VISITING

During 1963 the staffing situation of full time health visitors has been very satisfactory and for most of the year there has been a full complement of 25. This has proved very beneficial in every way: there have only been very short periods when it has been necessary for one health visitor to relieve another, and consequently each one has been able to devote the whole of her time to her own work. The arrangement whereby the work in the rural areas is carried out by district nurse/midwife/health visitor has continued, and here again the staffing situation has been satisfactory. There are 40 nurses undertaking this work, 18 being fully qualified health visitors and the remainder working as before under special dispensation from the Ministry. The nurses without the health visitor's certificate are slowly being replaced by the qualified health visitor. Although the scholarships for health visitors training are taken up each year, there is, as is natural, a movement of staff often resulting in a qualified health visitor going to another part of the country; thus the overall increase in qualified staff does not progress as rapidly as I would wish.

During the year 58,847 visits have been made to children under five, as shown in the following table:—

Health Visiting

Year	No. of children under 5 years of age visited during year	Children under 1 year of age	Children under 5 years
		First visits	Total visits
1959 ...	17993	5438	67114
1960 ...	18404	4054	62286
1961 ...	18170	4172	62085
1962 ...	18841	4176	55345
1963 ...	18737	4034	58847

In addition, 55,054 visits were paid to those over 65 years of age. Some very active work has been done by all the staff in connection with the elderly, covering such matters as liaison with the geriatric units in hospitals; arrangements for the supply of home helps; family visiting to assess the needs and thereafter referral to the appropriate person or organisation.

There have been many instances of voluntary help being used and it appears that, if only the wheels are put in motion, there is no limit to the help available. One nurse was able to enlist the help of a group of young men to decorate a downstairs room so that a grandmother, aged 90, could have her bed downstairs. The results were most satisfactory and there was a request from the young men for more work of a similar nature.

Three students who took their health visitors' training completed the course and are now working in rural areas.

As before, during the month of April, we welcomed twelve students from Bolton Technical College Health Visitors' Course for a week's rural experience in the county. This seems to be quite a "red letter" week and both students and staff once again enjoyed it to the full. The students gain knowledge of how the services are administered in a rural area, and benefit from the good Cumbrian air and perhaps a slightly slower tempo in life in a rural area which gives them time to look around and absorb ideas. The Welfare and Mental Health Officers, and the Children's Officer, co-operate with us and are always very willing to talk to the students. The nursing staff give unsparingly of their time to make the week both educational and enjoyable, and are glad to be able to show students the benefits and satisfaction they enjoy in their work in a rural area.

Secondment to General Practitioners

It is now generally accepted that the concept of general practice is changing and with it the concept of nursing and health visiting. It is no longer possible to have a line of demarcation between the preventive and the curative, or for each of the personnel involved to work in separate compartments. They are inextricably joined and must now and in the future work together for the benefit of all.

It is very encouraging to report that only two full time health visitors remain to be linked with the general practitioner group practices, and these will be seconded early in 1964. As this plan has materialised it is interesting to find that both general practitioners and health visitors would not like to return to the old method whereby each health visitor had her own area and often hardly knew the family doctor. Apart from one or two minor details the scheme has been so well accepted in the county it has become almost commonplace and the participants find it difficult to make any fresh comment. The main advantage is in making full use of the exchange of information for all categories of the family, the aged, the parents who may be under stress, the school children and the under five's. It is obvious now that the health visitor really cares for the family as was envisaged in the Working Party Report on Health Visiting, as well as in the National Health Service Act, 1946. The family doctor is well aware of this and appreciates more fully each year what can be achieved by full co-operation.

Although the health visitor's compact area may have disappeared the increased distances have not created the problems which were at first anticipated. It is essential, of course, that the health visitor should have motor transport, and this has been arranged from the very beginning of the secondment programme.

Help from Voluntary Organisations

The extension of the work of voluntary helpers in infant welfare clinics has been very beneficial to all concerned. The helpers are thoroughly enjoying their contact with the health visitors and the mothers and babies, as is evidenced by the following comments from the organiser of a group of Mothers' Union members.

"During the early part of 1963 our branch of the Mothers' Union was asked to provide some voluntary help at the infant welfare clinic at Flatt Walks, Whitehaven. Six members, all older women whose children have grown up, volunteered to share this duty, two at a time each Tuesday afternoon. On reporting at the clinic we weigh the babies, mark the record cards, and personal weight cards and sell the welfare foods. We find the work most interesting and enjoy the contact with the young mothers and

cannot but admire the beautiful babies, who are all so healthy and well cared for. The staff are very pleasant to work with and assure us we are a great help. We can realise how busy the health visitors must have been before we arrived; now they are able to spend time talking to and advising the mothers, both individually and in groups, rather than in doing the routine jobs. We really feel that we are doing a worth while job. The afternoon usually ends with a most enjoyable cup of tea".

Another helper of three years' experience says how much she looked forward to her weekly visit to the clinic where she enjoyed selling all the baby foods. This released the health visitors to show short films and give talks. All this quickly brought home to her the fact that voluntary help was much needed at the clinic.

The health visitors, while perhaps a little hesitant at first to share the work, have soon found there was more to be gained than lost. The voluntary helpers have taken over such duties as registration, weighing babies, looking after toddlers, organising a cup of tea, and all this help now allows the health visitor to do the work that only she is able to do and she appreciates the value of this. It is obvious that the voluntary helper is an important part of a successful clinic session.

Post Graduate Courses

The scheme which commenced towards the end of 1962 whereby the health visitors spend two weeks studying the modern methods of mental health treatment and care, continued, and 26 members of the staff spent two weeks at either Garlands Hospital or in the Psychiatric Wards at the West Cumberland Hospital. Very interesting reports were received from the health visitors after these visits. At first they all found it hard to adapt themselves to the much slower way of working, but as the days progressed and they became familiar with the work and treatment they appreciated more fully the importance of listening, and many of them felt they would have liked to have spent at least a month in the hospital. All agreed the time had been well used and the experience gained had been most valuable. The following comments summed up the general feeling for all who participated:—

"We visited the refractory and geriatric wards where we were able to observe patients with chronic mental disorders and study their behaviour patterns and treatments. We also worked in the new clinic block and all the units and saw the facilities for the treatment and care of the acute mentally ill patient. We were able to spend time talking with the patients, joining them in their activities, and observing them during and after treatment. We became familiar with some of the drugs, such as the tranquiliser Largactil and its derivatives, anti-convulsant drugs and the anti-depressive drug Tofranil. Helpful and interesting discussions took place with the doctors, sisters and social workers and we felt we had in this brief time improved our concept of the modern treatment of the mentally ill".

The co-operation and help of the hospital medical and nursing staffs ensured the success of the scheme and I am very grateful to them.

Two health visitors spent two weeks at the refresher course on the Principles and Practice of Health Education held at Bolton, and found it most stimulating and helpful in every way. They shared their knowledge and experience with their colleagues at a staff meeting, thus passing on the latest ideas on this subject.

Staff meetings have been held at regular intervals throughout the year, usually including a special speaker. Miss M. Silva Jones, Children's Officer, and Mr. R. B. Neal, Chief Dental Officer, talked about the newest trends in their particular fields.

Two health visitors have assisted throughout the year at the child guidance clinics and they find the work interesting, particularly as it links very closely to their work with the family doctor. The reason for a child visiting the clinic may be found to be a physical one, as was instanced in a child with enuresis who, after a pathological urine test initiated by the health visitor in consultation with the family doctor, was found to have a physical condition requiring treatment. This was started and the improvement was very soon apparent and the child back to normal, thus quickly eliminating the stress in the family as a whole.

HOME NURSING

For many years it has been my aim to ensure that all nurses undertaking general nursing of patients in their own homes should be fully qualified State Registered Nurses, and where possible hold the additional qualification of the District Nursing Certificate. It was mentioned in last year's report that approval had been given by the Queen's Institute of District Nursing, and agreed by the Health Committee, to train for the District Nursing Certificate, those members of the nursing staff who were eligible. Their practical experience would be taken on their own districts and the three weeks' block lecture course at one of the Queen's Training Homes. The first six nurses, all from West Cumberland, commenced training on January 21st, and while somewhat apprehensive regarding the theoretical content of the course, were certainly most enthusiastic to enter for training. Miss Blockey, Deputy Superintendent Nursing Officer, acts as Tutor to the Course, undertakes supervision of the practical work and gives tutorial classes and demonstrations. Arrangements were made for the students to attend at Middlesbrough and Liverpool Training Centres for the three week block period, and we are indebted to these authorities for the help they gave in this respect. All six nurses passed the May examination and were awarded the Queen's and National Certificates of District Nursing. A further two candidates commenced training in May and were successful in passing the September examination; one who commenced training in September passed the January, 1964 examination, making a total of nine successful students. All the nurses were very pleased with the results and expressed their appreciation of having been given the opportunity of taking the training. On completion of the course they made the following comments—

"Even though having worked on the district for many years, the district training was very interesting and enlightening. Previous to this I did not fully appreciate all the various amenities which are available to the public through the National Health Service. I now realise the district nurse has one of the most important duties to fulfil in the health service, not only with nursing but by liaison with the doctors, health visitors, hospital staff, and all members of

the health team, for the essential well-being of the patients and their households. I feel that the Queen's District Training Course was definitely to my advantage".

"Being a nurse of several years hospital experience, I thought it would be easy to nurse patients in their own homes, but I was mistaken and can say with authority that it is essential to have district nursing training on taking up the work, both for the benefit of the patient and the nurse".

"When last year it was suggested to me that I might like to do my district training, I was keen on the idea but a bit nervous. At 46 years of age with a husband and two young children, it seemed a rather big undertaking; but with encouragement and the promise of co-operation from my husband I decided to say 'Yes'. Now with my training behind me and a Queen's and National Certificate in my possession, I am more than pleased I made that decision. The benefits I received far outweighed the snags that arose and I would recommend this course to any nurse whatever her age".

It has proved to be a success and well worth while. Miss Blockey substantiates this and says—"Although this was a completely new venture, as all the nurses taking the training had worked in the county for many years, it proved to be most interesting. The whole approach to the training was so different from the approach of junior nurses. One is left with the impression that there is a lot to be said for this more mature outlook and attitude. Everybody, including myself, enjoyed the course immensely and we are all grateful for the help given to us by the other members of the staff of the County Council who took part in this training".

The number of nurses undertaking home nursing duties, either full-time or as a part of the work, who hold the district nursing certificate is now 69, out of a total staff of 78.

Disposable Equipment

Disposable pre-sterilised syringes have now been in use for a full year and the staff are unanimous in appreciation of their value, giving the following as their reasons. A considerable amount of time is saved in not having to boil the syringes and needles: there

is no worry about breaking the syringe or the barrel becoming stuck; the syringes can easily be carried round, and disposal has not presented any problems. There is no anxiety regarding infection and it is a saving of gas or electricity for the householder—this being particularly important for the old age pensioner.

Ministry of Health Circular 14/63 extended the use of incontinence pads to all patients where neceessary, whether nursed by the local authority nurses or not. The wide use of incontinence pads has filled a long felt need, and used in conjunction with plastic pants for the more severe cases of incontinence, they have proved their value; the saving of washing of sheets and draw sheets is much appreciated by the patients' relatives and the home helps.

Laundry Service in Whitehaven

While this is a continuing service provided in conjunction with the West Cumberland Hospital Laundry, the demand has not been very great. This is due to the extended use of incontinence pads which already relieves the householder of washing soiled linen. In the seven households which used the Laundry Service during the year, the patients had illnesses of long duration and the constant supply of clean linen was a great help to their relatives.

Student Nurse and Pupil Nurse Training

Co-operation with the Cumberland Infirmary and the West Cumberland Hospital Nurse Training Schools has continued, and as formerly, lectures on the Social Aspects of Disease have been given to each group of student nurses by either the Superintendent Nursing Officer or her Deputy.

The district nurses and health visitors have enjoyed taking the student nurses round with them for a day to show them the domiciliary side of nursing care and this year 30 student nurses from the Cumberland Infirmary and 23 from Workington Infirmary (including 12 Enrolled Nurse training students) have visited patients in their own homes.

During the year arrangements were made for 22 student district nurses to spend three days in a rural area. We have had students from Gateshead, Stockport and Sunderland. This is of

mutual advantage, both to our nurses and the students; information exchanged can be of value to both. The nurses are always very willing and helpful in co-operating in this way. Staff meetings have been held regularly every three months in Carlisle and Whitehaven. In addition to current items of information, talks have been given by Miss M. Silva Jones, Children's Officer, on "The Children and Young Persons Act 1963—Extension of Powers of Local Authorities to promote the Welfare of Children", and Mr. R. B. Neal, Chief Dental Officer on "Dental Care for Children and Expectant Mothers". The nurses were also shown an excellent film to mark the Centenary of the British Red Cross Society—"Across the Street—Across the World".

A refresher course for district nurses arranged by the Queen's Institute of District Nursing, and held at Bangor, was attended by three nurses. Courses such as this are a good meeting place for nurses from all parts of the country, and the interchange of experiences and ideas is just as important as the lecture content of the course.

In November we were invited by the Queen's Institute of District Nursing to participate in their work study survey in connection with central sterile supplies research, which is investigating the possible use of central sterile supplies research, which is investigating the possible use of central sterile supplies in district nursing in both urban and rural areas. Three nurses in rural districts of varying geographical locality and population took part over a period of a month in recording the procedure carried out by them in all forms of sterilisation, e.g. boiling of instruments, baking dressings in the domestic oven, or using pre-sterilised syringes and needles. A comprehensive return was submitted which included the type of area, population, nearness of general practitioner, time taken in sterilising equipment, nursing or visiting a patient for other purposes, and in travelling. It was a time-consuming but interesting experiment for the nurses.

The Ageing Population

The largest part of the general nurses' work is among the elderly and it is interesting to find that, although in many cases the housing accommodation now provided for them has improved

out of all recognition, changing literally in some cases from the cottage without a water supply or toilet facilities to the centrally heated flatlet with all modern conveniences, the problems of the elderly unable to look after themselves still persist. These problems are of course alleviated, but not eliminated, as one nurse explains in the following report—

"This old lady has not quite maintained the level of health she had reached on discharge from hospital. She is up and dressed each day but is not always getting sufficient food, mainly because she does not always eat the food prepared for her. There are days when she does not take the medicines prescribed, the difficulty being that there are four different drugs which, although clearly labelled, confuse her so that she does not take any of them. She continues to live in her flatlet but needs a lot of supervision".

On looking back over the last few years it is obvious how the pattern of general nursing care has changed. Quite a large part of the nurse's day may now be taken up with visits of a "social advice" nature. There is no "end result" to be seen, and nurses used to practical results are apt to feel dissatisfied with their work. It takes some time for a nurse to adjust to this new outlook, but the more the preventive attitude is brought into the present nurses' training the easier it will be in the future. The domiciliary nurse of the future, who will be working closely with the general practitioner, will no doubt have voluntary helpers from various sources attached to her to whom she can give some instruction and who will be able to help her in visiting the lonely, or by sitting up at night with a patient. Members of many voluntary societies are already participating in this work.

The British Red Cross Society has agreed to take over the distribution of loan equipment from three centres based on Carlisle, Workington and Whitehaven respectively. At the time of writing this report each of these depots has already been established and become operative and I am very grateful to the Society for undertaking this work.

In October, the Chest and Heart Association arranged a conference at Lairthwaite School, Keswick, on 'Stroke' Rehabilitation. It was the first time such a meeting had been held in Cumberland

and it was very well supported by both hospital and domiciliary staff. Many members of local voluntary organisations and lay personnel were present. The Chair was taken by Alderman R. F. Dickinson, J.P., Chairman of the County Health Committee. The programme which was most comprehensive covered all aspects of the care necessary for those recovering from a 'stroke', including the following:—

What a 'stroke' means to the patient.

What a 'stroke' means medically.

Psychological aspects.

Domiciliary rehabilitation.

It was evident from the interest shown at question time that the audience appreciated this opportunity of discussing the problem, which concerns so many people in all walks of life. Early ambulation, and education of the relatives in how to manage a 'stroke' patient at home, which is available through the hospital and domiciliary nursing services, does go a long way to assist these patients back to a normal way of living. This work is further commented on in the section of this report headed "Domiciliary Physiotherapy Care". The British Red Cross Society had an excellent display of aids for the disabled which are available on loan to patients requiring them.

Home Nursing

		Total number of persons nursed during the year	Aged under five at first visit	% of total cases nursed	Aged 65 or over at first visit	% of total cases nursed	Malignant Disease	% of total cases nursed	Remaining cases	% of total cases nursed	Total No. Nursing Visits.
1959	...	7774	574	7%	2496	32%	237	3%	4467	58%	135,764
1960	...	7072	513	7%	2489	35%	210	3%	3860	55%	127,596
1961	...	6375	390	6%	2495	39%	213	4%	3277	52%	127,610
1962	...	5696	381	7%	2893	51%	237	4%	2185	38%	117,648
1963	...	6083	455	7%	2933	48%	248	4%	2447	41%	125,266

IMMUNISATION AND VACCINATION

The only important change in the immunisation and vaccination programme in 1963 followed the Ministry of Health Circular 10/63 in May, concerning poliomyelitis vaccination. I deal with this a little more fully below.

The main work in the field of vaccination and immunisation is concentrated upon the child population and every effort was continued during the year to attain higher immunity rates against diphtheria and poliomyelitis. I believe that the sustained efforts of the entire nursing staff of the department in contact with parents of young children has contributed significantly to the degree of success that has been achieved in improving the figures for diphtheria immunisation. I am sure that this is also associated with the increased attendances at child welfare clinics and with the still expanding programme of secondment of nursing staff to general practitioners.

A very full programme of school visits was built up and maintained during the year and the co-operation of the teaching staffs in the schools has made an important contribution to the work, as well as the intensive work of the medical and nursing staff. As mentioned in a little more detail below, the introduction of a reinforcing dose of poliomyelitis vaccine for all school entrants introduced during the summer means, as the situation stands at present, that each school requires yet a further visit by a doctor and a nurse. I hope that the expert advice passed on by the Ministry of Health will soon allow of reinforcements against diphtheria and tetanus being given at the same time as oral reinforcements against poliomyelitis.

The use of pre-sterilised disposable syringes is already so well established that the staff visiting schools in particular could not think of a return to the old arrangement of portable sterilising equipment of less than fully guaranteed efficiency. Not only is time saved for the medical and nursing staff, but the interference with school work is also significantly reduced. Dr. Campbell reports as follows on a visit she made to the manufacturers of these disposable syringes following certain technical difficulties:—

"A very interesting, informative visit was paid giving me the opportunity of discussing certain difficulties encountered in the use of disposable syringes.

One which arises is a certain wastage of vaccine due to retention in the nozzle owing to its shape. As yet this has not been overcome. Previously needles were adherent to syringes resulting in wastage of syringes and vaccine where needles were loose and leakage occurred. This has been corrected by producing separate syringes and needles.

An obstinate airlock, proving time consuming, is sometimes encountered in filling.

The disposable B.C.G. syringe is a first class syringe, easy to fill, smooth running, with none of the leakage backwards previously encountered in the old glass syringes".

The overall increase in immunisation and vaccination work undertaken in clinics and in schools, together with my determination to improve the county's figures has contributed to my recommendation, which I am glad to say the Health Committee has accepted, that a further full time assistant county medical officer or the equivalent in part time services, should be available as from April, 1964.

(a) **Diphtheria Immunisation**

The following table sets out the total number of immunisations against diphtheria carried out annually during the past ten years, and it will be seen from this that the numbers of pre-school and school children immunised during 1963 was the highest recorded during this period:—

1954	...	...	...	....	6,680
1955	...	...	...	...	9,463
1956	...	....	...	...	5,221
1957	...	...	...	...	7,127
1958	...	...	...	...	4,024

1959	5,077
1960	8,245
1961	5,222
1962	7,132
1963	10,644

The 1963 figure of 10,644 can be broken down as follows:--

Primary courses	5,108
Reinforcing injections	5,536
	10,644

Sixty-five per cent of the primary courses were in respect of pre-school children.

The immunity index for 1962 as calculated by the Ministry of Health Statistical Branch is as follows, along with a local calculation of the index for 1963:—

Year	*Age 0 - 2*	*Age 0 - 14*
1962	69	53
1963	72	55

This index shows the percentage of children in the age groups indicated who may be regarded as adequately protected against diphtheria by virtue of having received a primary or a reinforcement immunisation within the last 5 years.

Reinforcement injections against diphtheria are offered to children at school entry and again at 10 years of age. The numbers of children receiving the recommended reinforcement at eighteen months is also slowly being increased and I look to the health visitors primarily to keep this figure moving upward. Each child reaching the age of one year receives a birthday card from the department reminding the parents amongst other things, of the

advised programme of vaccinations and immunisations. Since it is now recommended that smallpox vaccination should be carried out during the second year, this provides a useful opportunity to ensure that the diphtheria reinforcement due at eighteen months is also an accepted part of the programme for the second year of life. My aim is to build up the immunity index for the total age group 0—14 to a minimum figure of 65. I believe this can be achieved most effectively by the health visitors working both in the clinics and in close conjunction with general practitioners. The possibility of a serious reappearance of diphtheria is a constant anxiety unless the childhood immunity state is pressed even higher.

(b) **Whooping Cough Immunisation**

The number of children who have completed a primary course of whooping cough immunisation during 1963 was 2,938. The majority of these courses are of course given in early childhood as part of the triple protection against diphtheria, whooping cough and tetanus. Therefore this figure of 2,938 corresponds quite closely with the number of primary courses of diphtheria immunisation (3,315) given to pre-school children. It is not necessary or advisable for reinforcement of whooping cough protection to be given at school entry age or later, at the same time as diphtheria and tetanus protection are being boosted. The vital age for protection against whooping cough is in early infancy. 119 cases of whooping cough were notified in the county in 1963, the highest since 1960, when 392 cases were notified. The age distribution of the cases notified is as follows:—

Under 1 year	3
1 year	15
2 years	12
3 years	17
4 years	15
5—9 years	53
10—14 years...	4
	119

Only a high level of infant protection will eliminate this distressing condition amongst children with its sequelae in some cases of long term chest disability. The occurrence however of cases of whooping cough and of the rare case of tetanus should continue to reinforce in the minds of parents the great importance of a high level of protection in their children against these serious infectious diseases.

(c) **Tetanus Immunisation**

During the year 6,842 children received a primary course of injections against tetanus and 3,337 were given reinforcing injections. The primary courses were linked as mentioned above, with diphtheria and whooping cough protection in young children in the majority of cases, although of course school entrant children as yet unprotected against tetanus are given primary protection then. The scheme continues for passing information to the casualty surgeons in East and West Cumberland and to the general practitioners of all children protected against tetanus at County Council clinics or schools. It is not an easy matter to evaluate this arrangement which is of long term consequence.

I quote from the comments of Mr. Turney, Casualty Surgeon, West Cumberland, on the value of the scheme to the Casualty Department, West Cumberland Hospital:—

"May I thank you and your staff for enabling us to build and maintain this record of children who have been protected against tetanus. It has been of invaluable aid in the treatment of many cases both here and at Workington Casualty Department, and saved many a child from the second injection which the serum calls for, as well as saving parents and patients from the hour's wait which is also necessary when administering Tetanus Anti Toxin".

(d) **Smallpox Vaccination**

The number of children under one year of age who received primary vaccination during the year was 786, a take-up rate of only 20% of infants. In addition 396 other persons received primary vaccinations and 176 were revaccinated. The number of primary vaccinations of children under one year thus

shows a substantial decline from previous years. In November, 1962, a Ministry of Health circular advised that the vaccination of young children should preferably be carried out during the second year of life. Assuming that this has been given effect to generally, a low figure for one year is inevitable. While there is much discussion within the profession about which groups of the population should be vaccinated against smallpox and at what ages, I am satisfied that it is prudent still to aim for the highest possible level of vaccination of children.

(e) **Poliomyelitis Vaccination**

In May, 1963, Circular 10/63 was received from the Ministry of Health giving the latest advice on the administration of oral poliomyelitis vaccine. Apart from reinforcing earlier advice that the maximum level of vaccination in the community should be aimed at, especially amongst children, there was detailed advice on the completion of protection of any who had commenced Salk vaccine. In addition a plan of campaign was advised whereby any case of paralytic poliomyelitis occurring would be "ringed" by the emergency administration of a single dose of oral vaccine to all children in the neighbourhood of the case.

The advice in this circular, however, which required the most immediate action, concerned children entering school who should all now receive a reinforcing dose of oral vaccine.

I doubt if it is any longer meaningful to show the table that I have published in previous years indicating the total numbers of people vaccinated to varying degrees of completeness against poliomyelitis. The most important single figure available at present is the Ministry of Health's assessment that 88% of the county's population under 20 were vaccinated against poliomyelitis at the end of 1962. This figure compares very favourably with most other authorities. It is interesting to note that by now everyone reaching the age of 20 has come within the scope of the schools poliomyelitis vaccination programme which started in 1957.

During the year 4,205 primary courses were completed and 5,342 reinforcing doses were given, these being distributed as follows:—

	No. who received primary courses	No. who received reinforcing doses
Pre-school children	3,069	1,630
School children	304	3,004
Children and young persons born 1943-1948	88	82
Young persons born 1933-1942	355	254
Other ages	389	372
	4,205	5,342

The great majority of the primary courses were given to young children in the course of their normal series of vaccinations and immunisations in the first 2 years of their life. Most of the reinforcing injections were given to children between 5 and 12 in accordance with the Ministry's earlier recommendation, and later in the year to school entrant children as most recently recommended. The principal objective of the poliomyelitis vaccination scheme therefore in the future is to ensure that both the above totals approximate as closely as possible to a total year group of births in the county, i.e. approximately 3,800. This would show that the infants were being protected in their first year primarily, and a year's school entrants were being reinforced at 5 years of age in their turn.

Advances both in the matter of materials used for poliomyelitis vaccination and in the optimum spacing of doses have continued, and produced varied patterns of injections and oral doses, depending on the time of commencement of protection. In addition, a quadruple vaccine is now manufactured which simultaneously protects against diphtheria, whooping cough, tetanus and poliomyelitis, and is being used to a limited extent by some general practitioners. The Ministry of Health have not, however, advised its adoption in preference to triple antigen plus oral poliomyelitis vaccine. There are inherent advantages in poliomyelitis vaccination being given by the oral route, apart altogether from the comfort and convenience of the method of administration.

AMBULANCE SERVICE

During 1963 the most important feature of the ambulance service has been the progress towards the completion of the Council's decision that a full time ambulance service should replace the contractual service. It will be remembered that in June 1962, the first phase of the new service was introduced in East Cumberland with stations at Penrith and Carlisle.

The appointment with effect from 1st May, 1963, of Mr. M. F. Smith as County Ambulance Officer marked a most important stage in the development of the service.

Plans have advanced for the building of new stations at Distington and Wigton, and these should become operational at the beginning of 1965. From these bases the major part of the county will be covered by a direct service. The Distington station serving the most populous area of West Cumberland will employ 25 men, and be the base of 4 ambulances and 4 dual purpose vehicles. Wigton in its turn will be the base for 7 men and 4 vehicles. A thought which was grafted on to the planning of the West Cumberland station during the year was the establishment of three substations at Maryport, Egremont and Cockermouth, where an ambulance will be stationed during the hours of night as first local call in these areas. This is combining the best of both the new and the old to suit these particular areas.

In East Cumberland a new ambulance station is planned for Halfway House, Penrith, and it is hoped that as many of the services as possible will be used jointly with the County Fire Service there.

A special situation arose however during the year at Millom when the contractor applied for a substantial increase in his contract figure. Although this was granted at the time it was also decided to terminate his contract and establish a direct service in Millom from 1st October. The belief that this could be done without substantially increasing the cost of the service, is being borne out in practice. Suitable garage accommodation requiring very little adaptation was rented, along with a room for office

purposes. A staff of 5 driver/attendants, including a foreman driver, was appointed, and a new dual purpose vehicle was added to make up a small fleet of 1 ambulance and two dual purpose vehicles. I am very satisfied with the success of this station at Millom.

Related to difficulties which arose at the Bush Brow Station in Carlisle is the fact shown in the following statistical tables that the demand for ambulance transport continues to increase steadily. While this is largely associated with the development of community care in relation to hospital and general practitioner services, there was in fact a very marked increase in the amount of emergency work, especially in East Cumberland, out of normal day shift hours. A review became necessary of the arrangement whereby night calls requiring to be dealt with from the county's Bush Brow Station in Carlisle were passed to drivers on call at home through the Carlisle City Ambulance Service, and it was finally decided that the only completely satisfactory solution was the establishment of a county station manned 24 hours a day in Carlisle. This involved the increase in the establishment of the station by 7 driver/attendants. At the same time it was decided to pursue discussions with the Carlisle city authority with regard to possible future integration of the City and County Ambulance Services based in Carlisle.

A further matter in which some significant progress has been made is the training of the driver/attendants. Anticipating a national pattern of training for these officers, a pilot advanced first aid training course was arranged between September and December in which all the ambulance authorities represented on the Ambulance Liaison Committee co-operated in sending men to a series of 8 lecture discussion meetings at the Cumberland Infirmary. In this we were admirably served by the consultant and other hospital staff who have obviously a very keen interest in the training of ambulance personnel. Everyone found the course both helpful and stimulating and I am grateful to those who did so much to make it a success. The Liaison Committee referred to, which was re-established in May, 1963, has I am sure a most useful function to perform, although frequent meetings have not been found necessary. Its discussions help to consolidate the efforts which are constantly being made to co-ordinate journeys undertaken by neigh-

bouring authorities. The Chairman at these meetings is the Principal Regional Officer of the Ministry of Health, Newcastle.

With regard to the use of radio-telephony in the ambulances in East Cumberland, while this has undoubtedly proved an advantage, the maximum benefit from this facility will only be seen when the entire county service is directly operated. Until now the East Cumberland service has used the police radio network. The reorganisation within the police, which will result in more police vehicles using the frequency, has produced the need for reconsideration of the advisability of continuing to use the same frequency as the police. Discussions on this subject are proceeding at present.

A complete review of the fleet of vehicles in use in the service in the county has been made and a long term financial arrangement arrived at to enable the immediate provision of the necessary vehicles to operate the new service efficiently from its inauguration. Standardisation on one make of ambulance is likely to prove an advantage in many ways as the years pass. In parallel with this it is of note that drivers in Carlisle and Penrith were entered in 1963 for the National Safe Driving Competition organised by the Royal Society for the Prevention of Accidents, and in addition drivers are being encouraged to take the driving test of the Institute of Advanced Motorists. The County Council has agreed to pay the test fee and the first annual subscription. These are, I believe, important moves towards maintaining the very highest possible standard of service from the driver/attendants and link with the above-mentioned advanced training in first aid.

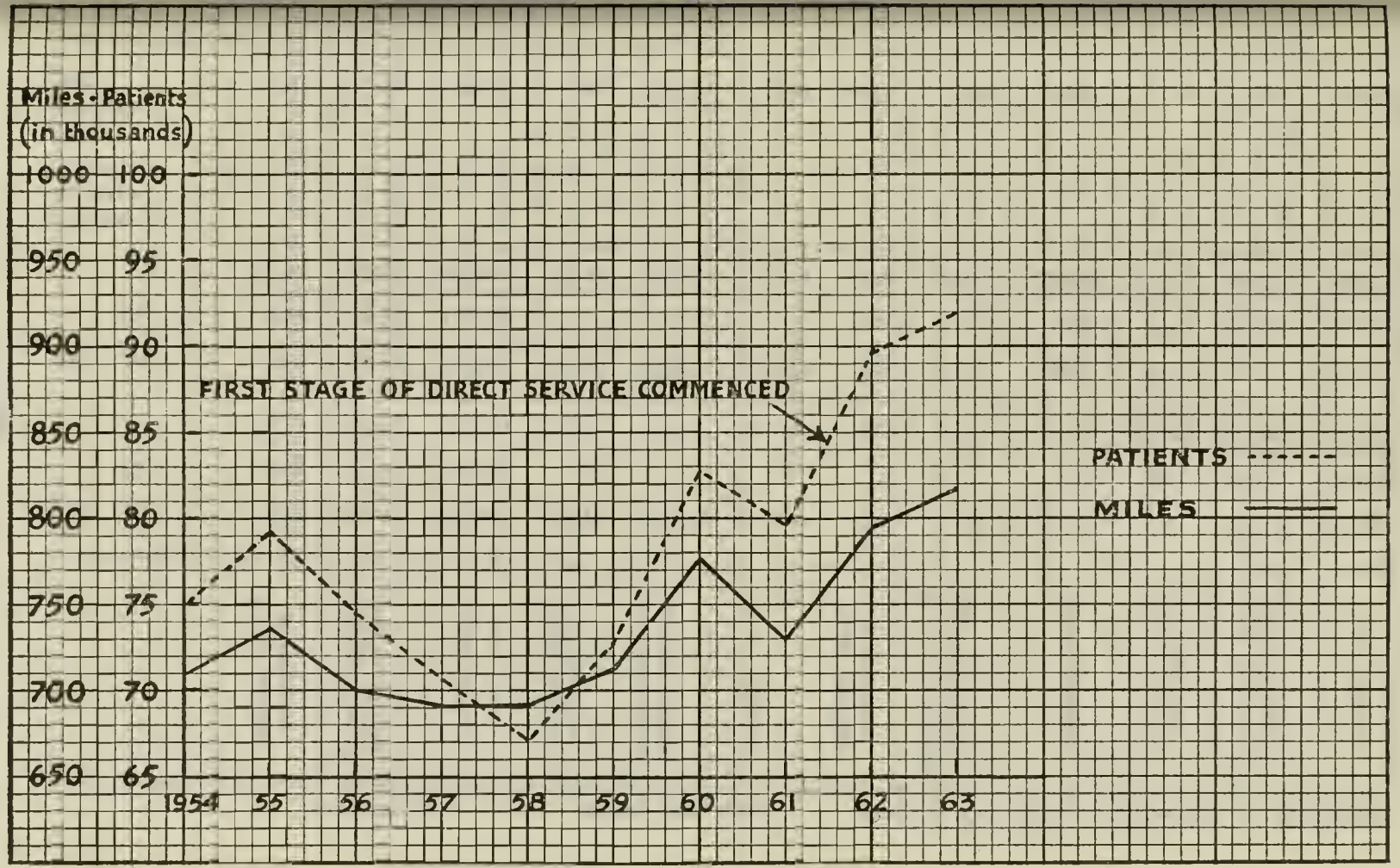
The following statistics and graph for the past 10 years show that the demand for ambulance transport continues to increase, and it is likely that this trend will continue as the health and welfare services expand. It will be seen that in 1963 the mileage increased at a slightly higher rate than the number of patients carried. This is mainly accounted for by the increase in the number of longer journeys, particularly to the Newcastle area. Every effort is made to arrange for ambulance transport by rail where possible, and the fullest co-operation is sought with neighbouring authorities.

As the principle of community care becomes more and more firmly established in relation to all illnesses, physical and mental, the ambulance service is certain to share in the far-reaching effects. A shortened stay in a district general hospital for an increasing number of patients inevitably means a steady build up in ambulance transport for out-patient attendances. This trend must be further accentuated by the fact that an increasing number of those so carried are in the 'elderly' age group—a group steadily and relentlessly growing and affecting forward thought on every aspect of the department's work. Having mentioned the district general hospital in this context it must also be realised that this principle of hospital provision, already operative in Cumberland, in itself implies an increase in ambulance transport. The case previously transported from the northern part of West Cumberland to Workington Infirmary must now be carried 9 miles further to the West Cumberland Hospital at Hensingham. This applies now to all cases excepting geriatric and obstetric. Even with regard to much of the southern part of this area the transport distances will be increased because of the geographically eccentric situation of the new hospital in West Cumberland.

While developments such as those cited above within the National Health Service are producing their inevitable effects on the ambulance service, other changes in the national face of the wider world of transport generally, may also have an important bearing on the subject. Until all of the changes to be effected by the Beeching plan for the railways are clear and finalised, it will not be possible to estimate accurately how these may effect the ambulance service. Although there is little rail transport of sick persons within the county itself, the longer distance journeys preferably undertaken by rail may be complicated by closures in different parts of the country. Already difficulties have arisen in consequence of railway modernisation in the shape of the replacement of steam by diesel fuelled locomotives. The design of the carriages and compartments of the latter do not allow of the normal stretcher being manoeuvred in and out. Where this occurs there is no alternative to a long distance road journey by ambulance.

It will be seen then that widely ranging local and national developments will undoubtedly have effects on a service which is in

facts surely underscore the necessity, if indeed not the urgency, of the establishment of an up-to-date, properly controlled and increasingly trained service. It is very gratifying that the Council has supported this development so helpfully so that its early completion is in sight.


Miles · Patients
(in thousands)
1000 100
950 95
900 90
850 85
800 80
750 75
700 70
650 65
1954 55 56 57 58 59 60 61 62 63
FIRST STAGE OF DIRECT SERVICE COMMENCED
PATIENTS
MILES

		Ambulances			Sitting-Case Cars			Hospital Car Service			Summary of all Services		
		Total number of journeys	Total number of patients carried	Total mileage	Total number of journeys	Total number of patients carried	Total mileage	Total number of journeys	Total number of patients carried	Total mileage	Total number of journeys	Total number of patients carried	Total mileage
1962	A. ...	9917	18181	202444	18472	59548	441644	483	1243	21973	28872	78972	666061
	D. ...	3696	10783	126836	—	—	—	—	—	—	3696	10783	126836
		13613	28964	329280	18472	59548	441644	483	1243	21973	32568	89755	792897
1963	A. ...	7391	12417	152303	17931	57267	390254	324	833	18481	25646	70517	561038
	D. ...	5919	17899	216624	—	—	—	834	3174	41091	6753	21073	257715
		13310	30316	368927	17931	57267	390254	1158	4007	59572	32399	91590	818753
Increase or decrease compared with previous year	...	—303	+1352	+39647	—541	—2281	—51390	+675	+2764	+37599	—169	+1835	+25856

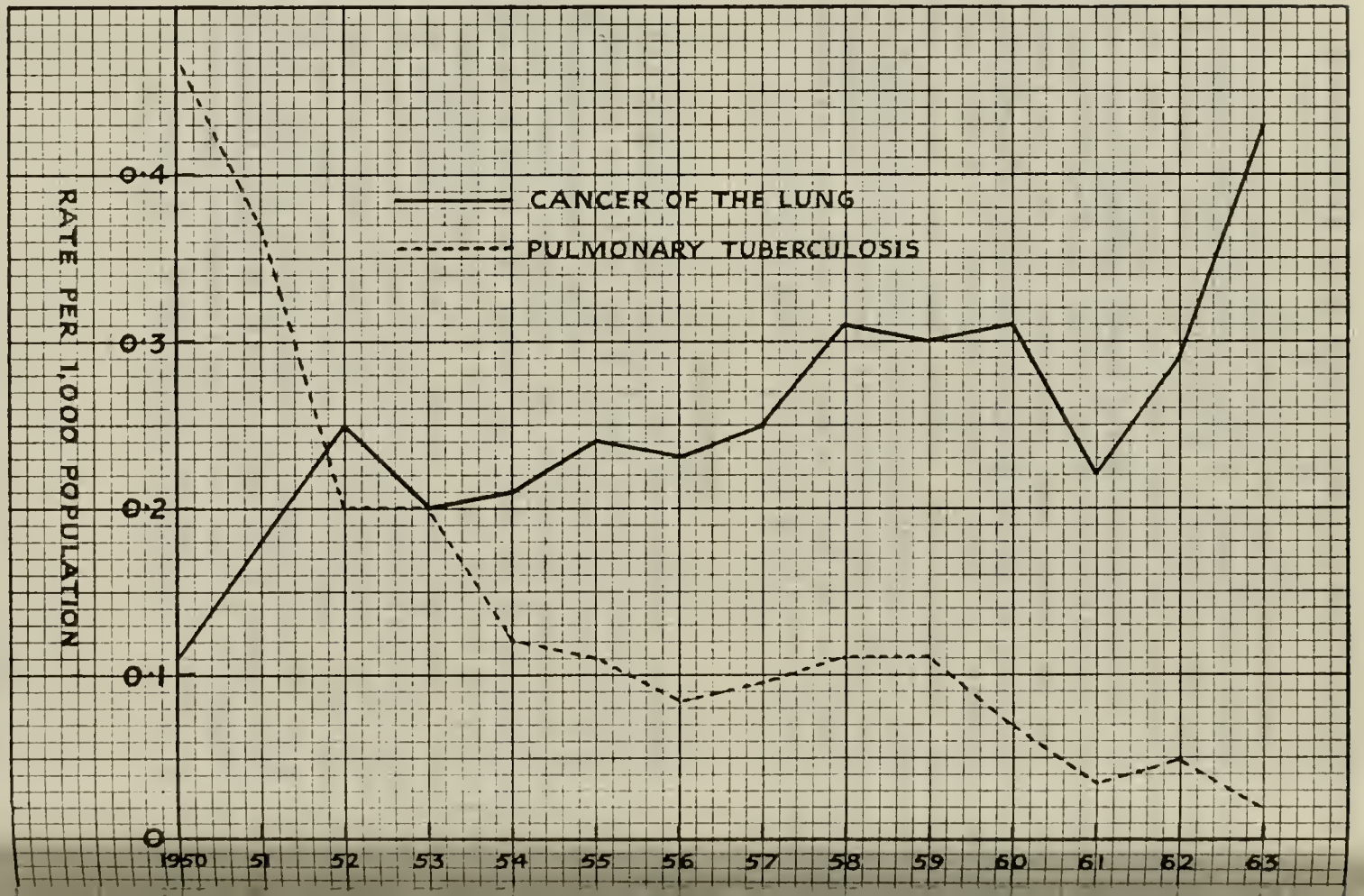
PREVENTION OF ILLNESS, CARE AND AFTERCARE

The purpose of Section 28 of the National Health Service Act, which confers wide powers on local authorities with regard to prevention, care and aftercare, is reflected over the years in the protean nature of the reports which have appeared under this heading. Tuberculosis once figured largely, although now overshadowed to a great extent by the expanding field of work in mental health and the serious issues underlying the need for health education against the hazards of cigarette smoking. Far reaching new legislation has also of course embraced much that was previously thought of and pursued under the umbrella of "Prevention, Care and Aftercare", thus while it is still useful to group certain of the items immediately following under this heading, it will readily be seen that this wide title could well in fact be written over the entire work of the local health services.

Tuberculosis

Notifications of pulmonary tuberculosis were reduced to 83 in 1963 from the previous year's figure of 94. A further reduction (from 22 to 12) was also shown in the number of deaths registered in which pulmonary tuberculosis was mentioned. Ten of these 12 were men, all in the older age groups. The table below of notifications by sex and age continues to demonstrate the higher incidence in older age groups of men. It is to be hoped that the impressive upswing of deaths from lung cancer, demonstrated in the graph which compares this with declining tuberculosis deaths, will alarm to the extent it should. More is said on this under the heading of "Health Education", and the subject is further highlighted in the reports of Dr. Morton and Dr. Hambridge Consultant Chest Physicians, in East and West Cumberland respectively. These are printed as appendices to this report.

DEATHS FROM CANCER OF THE LUNG AND PULMONARY TUBERCULOSIS



Aftercare of Other Illness

The following table indicates the major items of loan equipment which have been issued during the previous five years. No charge is made to the patient for this service and the continuing need for any particular item of equipment is reviewed annually.

Equipment	Items Issued During 1959	1960	1961	1962	1963
Commodes	15	34	49	76	98
Crutches	8	11	9	17	34
Hospital Beds	10	12	6	11	9
Invalid Chairs—					
Adult Type	69	71	83	105	141
Junior Type	10	11	11	10	7
Mattresses—					
Rubber	28	28	16	31	20
Inflatable	—	3	7	3	3
Tripod Walking Aids ...	35	53	46	91	127

From the figures above it will be seen that the demand for invalid chairs, commodes, tripod walking sticks and crutches has exceeded that of any previous year. I have received many expressions of appreciation from patients and relatives and it is becoming increasingly clear that the provision of modern nursing aids in the home is making a major contribution to effective community care.

One aspect of the service has caused me concern during the year; that is the vagueness of the dividing line between hospital and local health authority responsibility for the provision of appliances to patients. Stock checks have revealed that some equipment is kept on loan in some instances for a number of years. This particularly applies to wheelchairs. The hospital responsibility falls under Section 3 of the National Health Service Act and is circumscribed by the words "at or for the purposes of hospitals", and by a liberal interpretation hospital authorities can provide certain articles when they are requested for more permanent disabilities. This, however, does not mean that local health authorities are precluded from providing them and their field under

Section 28 of the Act can, within reason, be very wide. To help clarify the position meetings are to be held with the Hospital Management Committees and as a result of these meetings it is hoped that some guidance for the future can be given to general practitioners, hospital almoners and nursing staff when requesting equipment.

During the year a scheme was approved for the British Red Cross Society to establish loan depots in three areas of the County. These depots will conform with the proposed new regions of area administration which I mentioned earlier in my Report. The depots will be staffed by British Red Cross personnel for set hours during the normal working day and they will issue and collect items which were formerly distributed by the Health Department. Some of the heavier items, however, for which there is a limited demand will still be kept in the office at Carlisle.

The British Red Cross Society themselves run a scheme whereby a comprehensive variety of aids for the disabled are obtainable either from the Society or other stockists. I think that the administering of this service and the loan equipment scheme from the same source would be of great advantage.

Every opportunity which presents itself for stimulating voluntary help is being encouraged and with this trend in mind I am certain that the loan equipment scheme is essentially one which the British Red Cross Society are well qualified to operate.

Convalescence

Under the Council's scheme, patients who are in need of recuperative convalescence are assessed in accordance with their means, and contribute towards the cost of their convalescence.

The following table indicates the number of persons for whom convalescence has been arranged by the County Council over the last five years

Convalescent Home	1959	1960	1961	1962	1963
Silloth	31	38	35	55	51
Boarbank, Grange-over-Sands ...	4	—	1	1	—
Others	1	2	—	5	1
Totals	36	40	36	61	52

Recuperative holidays play a very valuable part in the scheme for the aftercare of patients recovering from illness or operation, and in addition a timely period of recuperative care can often avoid a complete breakdown in health, either physical or mental, and so has an important place in the prevention of illness.

For the second year the Home at Silloth was open during the winter months and consequently admissions were again quite high. Health Visitors continued to visit patients before admission, encouraging them to enter, and helping with any domestic problems associated with the holiday.

My Deputy or I attend the meetings of the Silloth Convalescent Home Committee, thus maintaining a link with the institution which is run on a voluntary non-profit making basis. At a maximum the Home accommodates 52 patients and most remain for a period of two to three weeks. The Home is situated on the Solway, where the air and climate is as bracing as anywhere in the United Kingdom.

Domiciliary Physiotherapy Care

In October, 1963, the Chest and Heart Association held one of their, by now well known, Conferences on stroke rehabilitation. This drew together at Keswick a large audience of interested bodies and individuals, including hospitals staff, general practitioners, and local health authorities staff, as well as the main voluntary organisations. From all of these sources, contributions were made

to the Conference and a very important feature was the role of physiotherapy in the home. This work, so clearly complementary to that of the domiciliary nurse, was dealt with by Miss Fraser at the conference. Along with Miss Morris she has contributed the following notes on stroke rehabilitation work and clinic and home care of children.

"It is encouraging to note that increasing use is being made of the Domiciliary Physiotherapy service for stroke rehabilitation and it can be of considerable value when used in the right way.

"It is essential that both the patient and his family fully realise their responsibility in carrying out the measures shown them by the physiotherapist to aid his recovery and regain his independence. They must clearly understand that the physiotherapist is not there merely to give a treatment which is then not repeated until her next visit. The physiotherapist's role is to show the patient and his relatives in the beginning how to carry out a full range of passive movements to each joint every day, following these with active assisted movements and progressing as quickly as possible to praticising the normal tasks of daily living, e.g., undressing dressing, feeding, washing and writing, even if they have to be carried out by using the unaffected arm.

"In the absence of complications it is important both to start treatment early and to progress as quickly as possible. The sooner the patient is out of bed, dressed and joining the family downstairs the better, and once he is attempting simple tasks about the house and getting out and about again amongst his friends and neighbours, he is well on the way to coming to terms with his disability"

In the treatment of children the domiciliary physiotherapists similarly instruct patients and parents in the exercises and activities to be persevered with at home. The type of case referred is generally that requiring long-standing supervision and the domiciliary physiotherapist becomes well known to the family and can provide a wide range of advice and help at home.

Follow-up of Registered Blind and Partially Sighted Persons—1959-1963

A.

	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
December, 1959—				
(i) Treatment (Medical, surgical or optical)	24	8	—	21
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	11	7	—	11
December, 1960—				
(i) Treatment (Medical, surgical or optical)	16	6	—	23
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	7	6	—	12
December, 1961—				
(i) Treatment (Medical, surgical or optical)	14	7	—	23
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	5	7	—	13
December, 1962—				
(i) Treatment (Medical, surgical or optical)	21	2	2	14
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	9	2	2	9
December, 1963—				
(i) Treatment (Medical, surgical or optical)	23	7	4	20
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	10	5	4	15

B. Ophthalmia Neonatorum: There were no cases notified during the year.

HEALTH EDUCATION

It has been apparent in recent years to most of the people working in this field that the time was ripe for a thorough review of the whole practice and content of health education which has tended to grow up over the years in a somewhat disjointed, though by no means ineffective, fashion. At local authority level the statutory responsibility has been upon local health authorities working in an important part of the field with the education authority, and complemented often by energetic work by voluntary organisations usually focusing on one particular topic, e.g., accident prevention. As this report goes to print the Cohen committee's report on health education has just been published and the government's reaction to its many proposals will be of considerable interest. It happens to coincide with a decision of the Cumberland County Council to appoint, as from early in 1965, a full time health education officer to the staff of the Health and Welfare Department, and the recruitment, training and further use of such specialist officers is a cardinal point in the recommendations of the Cohen report. I anticipate a considerable amount of discussion locally and nationally as to the emerging pattern of health education work as a responsibility of local health authorities. That the latter should remain central in the field is, I am sure, right. Health and education have many growing points in common today. The often perplexing problems concerning the direction of drive of the youth of the nation, which is increasingly engaging the minds of central and local authorities, is but one contemporary social difficulty which prompts a re-examination of one facet of health education.

In Cumberland in 1963 the department's work in health education has continued on the broad basis of individual and group work in clinics, schools, etc., a large part of this being taken by the department's nursing staff as recounted in some greater detail below. I regard the closer attachment of district nursing staff to general practitioners as a matter of considerable importance in this field. There seems no doubt that while nurses as well as doctors must be prepared in the future to learn the technique of, and undertake, more teaching work, nevertheless the authority inherent in their professional status must always be exploited to the full. The fact that the health visitor, whether in individual or group teaching

amongst families, clearly is of a team with the family's doctor, must I am sure enhance the authority of her advice and guidance. The very fact that this is no longer at risk of being in conflict with general practitioners counsel is a major step forward right away, although I believe the combined weight of their professional influence will in the long run prove the most important factor. Similarly in clinics and schools, the clinic or school medical officer along with the nurse, has an expanding part, I am sure, to play directly in health teaching. In the school situation, of course, they are further linked to the staffs of the schools whose professional discipline is teaching, and a sense of unity and coherence in their joint approach must be, and I believe is being, developed helpfully.

The new administrative arrangements within the Health and Welfare Department, whereby administration will be on an area basis should, I also believe, make its own contribution to a more local sense of purpose in health education as in other aspects of the department's work.

I concentrate the main part of the report on health education this year on the two topics singled out by the Ministry of Health for special mention, together with an account by Miss Mansbridge, Superintendent Nursing Officer, of the many and varied ways in which the nursing staff play their roles in health education.

Smoking and Health

The approach to this problem has been threefold during 1963. In the first place the pressure of posters, pamphlets, bookmarks, etc., advertising of the health hazards associated with cigarette smoking has been maintained through clinics, offices, schools, libraries, etc. The district medical officers have co-operated in this by seeking out local situations where such material would be acceptable and is likely to be most effective; and the nursing staff have dispersed similar material regularly. How effective this type of warning is to the community generally it is difficult, if not impossible, to assess, but it would be at least unwise to place too much confidence in it in competition with a now very familiar extensive and often subtle advertising approach by tobacco manufacturers.

The second prong of the attack has been directed to schools with concentration on the younger secondary school children. When the film "Smoking and You" became available it was decided to purchase a copy of this and encourage its wide circulation in the schools. It has been used extensively both in schools and youth centres and as often as possible with a school medical officer present to answer questions and take part in discussion.

Many head teachers commented on the effect of the film—one to the effect that the film made a greater impact on his junior than on his senior classes. A headmaster reports—"Everyone was most interested as evidenced by the large number of sensible and thoughtful questions asked of the school doctor afterwards. Whether seeing the film will influence any of them to be non-smokers I do not know, but many say they are determined not to smoke". A tutor at a further education centre commented—"I would say that the film had considerable impact on the children who are not yet habitual smokers, but was fairly rapidly shrugged off by those children who do smoke". Another head feels sure that many of his boys have given a great deal of thought to the problem, but is concerned about the possibility of the smoking habit being driven further underground.

I have no doubt these comments on the reactions of the children to films and talks on smoking and health is fairly representative of the thoughts of teachers and their pupils on the subject, and it is difficult to be very optimistic about the long term results until some continuity of interest is achieved in the schools. I am sure that the only secure way to achieve this is to stimulate participation by the children themselves in the campaign to prevent cigarette smoking in schools, and I hope in the current year that more progress will be made in this direction.

To supplement this work in schools, a visit was arranged from the Central Council for Health Education's mobile unit for two weeks in November. This unit consists of a mini-van carrying health education material and apparatus, and is staffed by two lecturers who work as a team. It was decided that during the two weeks spent in West Cumberland the unit would concentrate on junior classes in secondary schools. Dr. Dobson reports that the sessions spent in schools went very well indeed—the subject being

presented so as to catch interest without stimulating anxiety. He comments—"These sessions have probably made a real impact on some children, but the seeds of firm belief in the advisability of keeping off smoking are few in a very large field".

A third approach to the community health problem of cigarette smoking was attempts during the year to establish anti-smoking classes for adults who wished to give up the habit. One such attempt was made at a further education centre and considering that this was situated in a town of 12,000 population, it was initially gratifying to see as many as 20 individuals come along. A course of five meetings was held. There was an average attendance of 13 at each meeting. The films "Spotlight on Smoking" and "Smoking and You" were used, and a consultant chest physician took part in a discussion at one of the meetings. These were conducted on the group discussion basis. Many of those who attended expressed themselves as having been helped, though a month after the close of the course, only four could speak of having stopped smoking since the meetings. This occurred in May, 1963, and at the time of writing this report a twelve months follow up is being undertaken to assess the results. A further attempt was made to run a fresh course in September, 1963, but this proved very disappointing with only a few showing interest, and one wonders whether in a town of this size the majority of people seriously concerned about this problem were roped in to the first well publicised course.

The tutor of another further education centre in the county included an anti-smoking class in his prospectus for the term beginning September, 1963, but was disappointed to receive no registrations for the course at all. At the time of writing, a further effort is being made to conduct a similar course of discussion group meetings for those members of the staff of the County Council working in Carlisle who are concerned about this, and 20 have enrolled for these meetings which are being run at lunch time.

Commenting on the limited amount which the Central Council for Health Education's mobile unit attempted among others than school children, Dr. Dobson writes—"Other groups seem to be little

interested as when the unit was accompanied to a youth club. This was a thriving club with a membership freely using its facilities for entertainment but with a known reluctance to support discussion groups actively. These youngsters were no more than tolerant of film and talk alike. Not a single question was elicited, and little curiosity was shown by the two or three who took the opportunity to talk with the lecturers in the refreshment break that followed. The visit planned to a young wives group did not get even as far as this. Some members approached their secretary and were hostile enough to secure cancellation of the arrangement. These disappointing experiences emphasise the need to continue to study at a national level the value of the present day approach to the tobacco problem. There seems to be something amiss indeed when tobacco taxation can be increased in the confident expectation of yielding a vast additional revenue.

Health education is always a long term measure and the results are unlikely to satisfy the impatient. Yet 'long-term' in this field could well mean a further half-million or more lives lost through lung cancer. It will be a pity if stemming smoking is left to depend hopefully on a routine educational chore, whipped into prominence once a year when the deaths from lung cancer are announced."

The relative effectiveness of local efforts such as described above, and the weight of the potential of the mass media will probably always remain virtually impossible of accurate assessment, but it does seem at least reasonably likely that continued pressure and fresh approaches locally should have their own important contribution, as against the "immunity" to press and broadcast health education which seems to develop so rapidly. Whether something further could and should be done with regard to the national financial aspects of tobacco sales will no doubt continue to be hotly debated, but it does seem that something more from this direction would strengthen the hands of local heatlh authorities, even accepting that the ultimate basis of good health and habits must be education.

Venereal Disease

Along with smoking and health, prominence is asked for the subject of venereal disease in medical officers of health annual reports this year. Considering the width of the field of health education which local health authorities try to cover, an important element of selection of priorities will always apply to some extent, and in Cumberland the gravity of the situation with regard to venereal disease has never suggested that drastic measures were called for in health education. Although Dr. Bell's comments elsewhere in this report show that there is no room for local complacency on this subject, yet the problem has never reached anything like the proportions which it has in larger and more industrialised areas, and particularly of course in large seaport situations. With the help of the district medical officers of health the posters provided by the Ministry of Health have been exhibited as far as possible in the usual situations, together with information of local treatment centre facilities.

I did, however, call a meeting early in 1964 with Dr. Bell, Consultant Venereologist, a representative of the general practitioners and a representative of the Director of Education to discuss the present situation and the possible fields for further effort in the health education ventures which might reasonably be expected to affect venereal disease. I was not surprised to find that the general tenor of opinion was distinctly against venereal disease featuring centrally in talks or discussions with older school children, even accepting that the principal hazard is to those children whose parents are most defective in providing the pattern and atmosphere of life as well as the specific information which is helpful. The specific concentration on venereal disease seems less likely to be effective than the broader based "preparation for parenthood" approach.

This type of subject is certainly in increasing demand in the schools and while the hitherto more familiar subjects such as personal hygiene, care of the skin, etc., seem to be received with a certain impatience, topics at least leading up and related to the adolescent and moral behaviour problems being highlighted today seem more acceptable and are received in quite a serious and

responsible fashion. I am sure this must go forward steadily and carefully and mention should be made at this point of the valuable contribution which the Youth Counsellors of the Marriage Guidance Council are beginning to make in their talks and discussions with older school children. Two such counsellors are already very active in the authority's area, and more are expected to come into the field soon after training.

Further meetings and discussions with those most closely interested in this delicate but challenging aspect of health education will be arranged in due course, and I am sure the way ahead will become clearer as time passes.

Miss Mansbridge, Superintendent Nursing Officer, has contributed the following notes on the work of the nursing staff in health education.

"Health education is a continual process undertaken amongst others by nurses working in the domiciliary health field. The fact that the nurse is continually in the public eye, her every movement watched and her words listened to with interest and respect gives her fertile ground for sowing the seeds of health education, which can easily be offered to any age group and be reasonably well received. This of course is not always immediately apparant, indeed it may take years before the results show. Surely one must now feel how evident it is that our young mothers of today are benefiting from the education on health matters which they have received in various ways while growing up. It may have been through the school nurse, the health visitor, or the district nurse visiting in the home to nurse a relative. There is also the important media of talks which are given throughout the county in increasing numbers to Women's Institutes and Old People's Clubs. The increase in the number of projectors for use in the clinics, film strips and flannelgraphs during the year has helped; many talks have been given and a wide range of subjects has been covered. Our library of film strips in both East and West Cumberland is very comprehensive and leaflets and posters on all subjects are available for display in the clinics and distribution to the audience. Mothercraft talks have included, with others, Diet in Pregnancy, Keeping Fit in

Pregnancy, Breast Feeding, Normal Delivery, Dressing Baby, Weaning, Play Materials. This programme is given regularly in the mothercraft classes, which are held at various clinics as specified elsewhere in my report.

Another series of talks covers the health of the child and the adolescent, including such subjects as Birth to One Year, One to Five Years, Child Development, Emotional and Physical Development, the Value of Youth in the Community, Preparation for School Entrance, Behaviour Problems. All these subjects have been appreciated by the mothers at the clinics or at the Mothers' Clubs. There have been one or two successful talks given on Preparation for Adulthood and Parenthood, including the Physiology of Reproduction, the Birth of the Baby.

A subject with which we have been concerned throughout the year is the prevention of accidents in the home, particularly accidents by burning. Much time and thought has been given to publicity and talks have been given to the most vulnerable groups of the community, i.e., mothers of young children and to the elderly, with particular reference to the use of Proban treated flame resistant material.

The extension of the work of the voluntary helpers to all the clinics has allowed the health visitors more time for talking to groups of mothers, and where the health visitors also undertake school work the programme of talks to senior groups in schools has broadened.

A number of the staff have taken part in lectures to both senior members and cadets of the British Red Cross Society and the St. John Ambulance Brigade. The Duke of Edinburgh Award Scheme is very popular in the Secondary Modern Schools and here again the nursing staff have assisted.

Civil Defence (Training in Nursing) Regulations 1963. Circular 9/63. Classes were arranged for local authority staff, other than nursing, in First Aid and Home Nursing. They proved very popular and several classes were held at Carlisle and Whitehaven.

Throughout the year frequent group staff meetings were held in all areas of the county, where the subject of health education had a very prominent place, and I feel the continual meeting together and discussion on this subject makes the dissemination of the knowledge given to the general public much easier."

Summary of Talks, Films and Discussions

No. of meetings		515
Talks—		
Maternity and Child Welfare	23	
Health of the Child and Adolescent	26	
Sex Education	4	
Accident Prevention and First Aid	19	
Prevention of Diseases	11	
General Health Topics	61	
		144
No. of discussions in addition to above		30
No. of meetings at clinics		159
No. of meetings at schools		51
No. of meetings at Relaxation and Mothercraft Classes ...		32
No. of other meetings, voluntary organisations, etc.		275

CHIROPODY SERVICE

The chiropody service which the authority has provided free for the elderly, expectant mothers and the physically handicapped who are certified as being in need of it, has continued to expand steadily since its inception on 1st November, 1960. In the first fourteen months 2,153 people received treatment, another 1,152 were referred in 1962 and a further 968 in 1963. The number of patients receiving treatment at the end of the year was 4,273, of whom 3,335 went to clinics or to the chiropodists' surgeries and 938 were domiciliary cases.

These patients were given a total of 20,054 treatments during the year and it is interesting to note that 16,045, or 75%, were for women and only 4,009 for men. A further breakdown of these figures shows that 3,867 (19%) were domiciliary treatments and 16,187 (81%) were given in clinics or surgeries. Of the clinic or surgery treatments rather less than 1% were for the physically

handicapped and over 99% were for the elderly. Only 21 treatments—a negligible proportion—were for expectant mothers.

Under the County scheme the chiropodists are authorised to treat each patient referred to them (by a doctor or member of the authority's nursing staff) eight times during the course of a year, or, exceptionally and on medical grounds, as frequently as the need requires. The steady growth in the number of patients and the relatively slower growth in the number of chiropodists available has meant that in many cases the time between treatments has had to be extended, although priority has always been given to the more serious cases with an associated medical or surgical background. In the main, this element of selection in the appointments has probably had no detrimental effect on the patients and may indeed have helped to underline that it is a chiropody and not a pedicure service. However, one could not but be apprehensive if the trend towards "dilution" had to continue indefinitely. Most of the chiropodists in private practice who also see County patients now probably have as many as they can handle but the recruitment of a second full time chiropodist at the end of the year to work in West Cumberland should give a little respite. The situation has also been helped by the West Cumberland Hospital Management Committee's agreement to the termination of the arrangement whereby the full-time officer did hospital work during normal working hours. Instead he now does evening sessions in the hospitals. At the end of the year the staff consisted of one full-time officer and 16 chiropodists doing part-time work to the full-time equivalent of eight.

Some of the clinic sessions are becoming overcrowded but when the new chiropodist takes up duty this should be rectified by holding sessions in new locations, so cutting down the travelling for patients, a matter of some importance to the elderly in areas where public transport is infrequent. At the present time treatment can be obtained in 15 towns.

I am sorry to have to report that the statistics submitted by the full-time chiropodist, Mr. G. H. Thomas, M.Ch.S., show that once again around 10% of the appointments made were not kept. It seems that this is the figure one must accept and considering the

age group for whom the service mainly caters, it is probably not unreasonable. Nevertheless it does mean valuable time being wasted.

All the chiropodists not previously regarded as qualified under the Ministry's regulations have now been admitted to the new register established under the Professions Supplementary to Medicine Act, 1960, and are recognised as State Registered Chiropodists. This has meant that in the four areas where the service had to be operated through the agency of voluntary committees, it could be taken over and administered directly. I am indebted to these Committees and especially to their secretaries at Penrith, Wigton, Workintgon and Whitehaven, for the way in which they kept the service going: without their assistance those areas would have had a much reduced service. I would also like to thank the voluntary organisations which have arranged transport to get patients to treatment centres from outlying places.

The chiropody service is therefore clearly another in which the demands of a steadily expanding dependent elderly population are being felt. It is, however, a service which is more directly appreciated than many others and has served as the introduction in many cases to situations of varying degrees of isolation. A practical service offering so much in the way of real relief of discomfort can often do more than a great deal of propaganda to develop the confidence of elderly people than other services which are being provided for them. As day centres and day hospitals develop chiropody is a service which will be integral in their pattern and will, I am sure, attract to day centres many elderly people who would otherwise be reluctant to seek the friendship and fellowship of their contemporaries and those who try to help them. The supply of chiropodists, however, is likely to require the retention for some time of an element of selection in the treatment given, but I am confident that this will not be to such an extent that the secondary advantages which I have mentioned in the chiropody service will be seriously interfered with. any more than a significant dilution of the quality of the service.

VENEREAL DISEASES

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for his permission to publish the following extracts from his annual report to the Special Area Committee of the Newcastle Regional Hospital Board.

"For some years the following table has had a place in this report:—

Table 1

Year	Early V.D. Infections		Total Attendances	
	Carlisle	Whitehaven	Carlisle	Whitehaven
1952	51	13	2081	870
1953	43	17	1924	976
1954	48	18	1461	619
1955	48	26	1202	641
1956	60	23	909	450
1957	45	17	741	362
1958	45	22	806	301
1959	69	20	893	398
1960	74	20	920	472
1961	67	20	755	454
1962	70	52	640	473
1963	86	41	715	266

Early venereal disease infections these days include acute gonorrhoea and urethritis as well as syphilis in the first year of infection. In Cumberland they still show a progressive rise numerically, although the figure for 1963 at Whitehaven is less than in 1962. I am still much more concerned with the possibility of further trouble in West Cumberland and especially in Workington itself than I am with Carlisle. The factors which have caused such an increase in the venereal disease figures elsewhere in England are all to be found in the Workington area. It is a port, a centre of industrial activity and reconstruction. The industrial expansion has brought to the area numbers of contracting firms from elsewhere in the country, and their labourers and technicians constitute a force of male immigrants living at a distance from their own womenfolk. I am fortunate in receiving so much support, in combating this menace, from the Public Health

Authorities. Dr. Leiper and Dr. Hunter are ever ready with their help. In Workington the efforts of the "contact tracers" bring results which to me are little short of marvellous.

Concerning the female gonorrhoea contacts of male patients treated at the Cumberland clinics, it is noticeable for the first time that teenagers figure more prominently in the statistics than other age groups. In Cumberland the maximum incidence centres on the age group 18 (in Dumfriesshire the group is 17). Considering both the Carlisle and Whitehaven clinics together, the overall graph for gonorrhoea infections is still rising, whereas the statistics for the country as a whole show a downward trend which was first noticeable in 1961. Both locally and elsewhere the returns for non-gonococcal urethritis continue to reveal a numerical increase.

In 1961, the Council of the British Medical Association appointed a committee representing education authorities, the clergy, the medical, nursing and the social services to discover some practical method of dealing with venereal disease among young people. The Committee reported in March of this year. The content of this report contains more or less what I have been describing in this annual comment for some years past; moreover the press of the country gave the report a good deal of sympathetic and general publicity. Hence, I think there is no justification in going over the ground again. One point emerging from the deliberations of the Committee does require reiteration—that the problem is not primarily a medical one, but a social one. What the Committee failed to do was to give any lead to doctors, social workers, Church workers and so on. In this respect the report was a great disappointment. The Committee have recommended, however, that a central conference be convened with representatives of the medical and teaching professions, religious bodies and the social services to discuss its proposals and how they should be carried out. Likewise they thought local meetings in the branches and divisions of the British Medical Association could do much to arouse public opinion. One begins to suspect that nobody has the ultimate answer. Most venereologists, like myself, are continually writing, lecturing and warning and although we acknowledge that our advice may meet with sympathy or alert real interest, seldom does any intelligible reaction ensue. I am not prepared to believe

this is because of apathy in those to whom we address ourselves. I believe rather, the reason is a realisation of personal bewilderment. For myself although I deal with so many teenagers and their intimate problems, I cannot claim to see inside their minds. My faculty of understanding stops short somewhere. We adults just think and live in a "square" world and cannot penetrate the mystery of the modern "beatle" world. With the idea that it might throw up a few practical suggestions I recently asked two consecutive nursing training groups to tell me whether sex and venereal disease should figure in school instruction. Their verdict was almost unanimous—that guidance in both subjects was clearly necessary. They thought that instruction from parents would not be successful—especially since the kind of children who find themselves shipwrecked over sex or venereal disease have the kind of parents who would be incapable of giving instruction. They opted for instruction in school. I asked very pointedly at what age girls in school might best receive information about sex and venereal disease and was surprised to learn that the nurses regarded age 14 "as about right". This fits in with a recent statistical analysis by Sidney Laird, the Venereologist in the Manchester area. He analysed the scholastic attainments of his "under twenty" female gonorrhoeal patients and showed that the great majority had indifferent success at "O" levels. That is, the greatest danger as far as venereal disease was concerned, lay with the "early leavers", and not with "sixth formers".

At a useful discussion with the County Medical Officer and medical and educational colleagues, it was generally felt that direct instruction on venereal disease was not to be regarded as in place at present in schools.

The year 1963 produced another historical document dealing with venereal disease. This was the work of a Committee of the "World Health Organisation" dealing with gonococcal infections. (W.H.O. Technical Report series No. 262: Geneva.)

This document deals with the failure to control gonorrhoeal infection throughout the world. Gonorrhoea has become a "priority headache", as it were, to the World Health Organisation. Ample evidence has been forthcoming to demonstrate that neither

therapeutic measures nor epidemiological methods, so far employed, have been effective to stem the dissemination of the disease—in all regions of the world. This world study has shown that, "within the estimated limits of under-reporting and over-reporting, the greatest reservoir of infection was probably in the African region, in which the highest rates were found. Next to Africa came the Americas, although high rates were also reported from some countries in the Eastern Mediterranean region, South East Asia and Europe".

Recently I wrote in the Nursing Times, 10th April, 1964, "There are many factors which have contributed to this failure in mastering the disease . . . At the moment, W.H.O. is contemplating the foundation of a Central Medical Research Centre. Conceivably it might feature among its early projects a study of gonococcus."

Finally I append a table showing the place or origin of the new cases who attended the two clinics in Cumberland during 1963:—

Table 2

Town or Area	To Carlisle Clinic	To Whitehaven Clinic	Total
FROM—			
Carlisle and Suburbs ...	104	1	105
Arlecdon	—	2	2
Aspatria	4	—	4
Boot	—	1	1
Brampton ...	6	—	6
Cleator Moor	—	10	10
Cockermouth	3	5	8
Distington	—	2	2
Dumfriesshire	17	1	18
Egremont	2	7	9
Keswick	2	—	2
Longtown	6	—	6
Maryport	3	7	10
Millom	—	1	1
Northumberland ...	22	2	24
Penrith	20	—	20
Silloth	7	—	7
Wales	1	1	2
Whitehaven	4	24	28
Wigton	1	—	1
Wigtownshire	1	—	1
Workington	3	29	32
Others	21	—	21
	227	93	320

MENTAL HEALTH SERVICE

The impact of community care on the development of health services is, I believe, illustrated as clearly in the field of mental health as anywhere. The principles of the Mental Health Act, 1959, rest upon this premise. Alongside the actual provision of social support by trained workers, carefully linked with voluntary help, there is the all important requirement of progressive adjustment of community attitudes to the mentally disordered if a full and modern service is to be achieved. The close attachment of field staff to general practitioners, as well as the planned integration of voluntary help plays, of course, an integral part in this matter of the attitude of people at large to mentally disordered in their midst. This in turn links with the whole field of health education which pervades every aspect of the department's work.

I review below in some little detail the various main aspects of the department's work in the mental health field and I feel confident that this will be generally accepted as demonstrating significant progress during the year.

Domiciliary Care Service

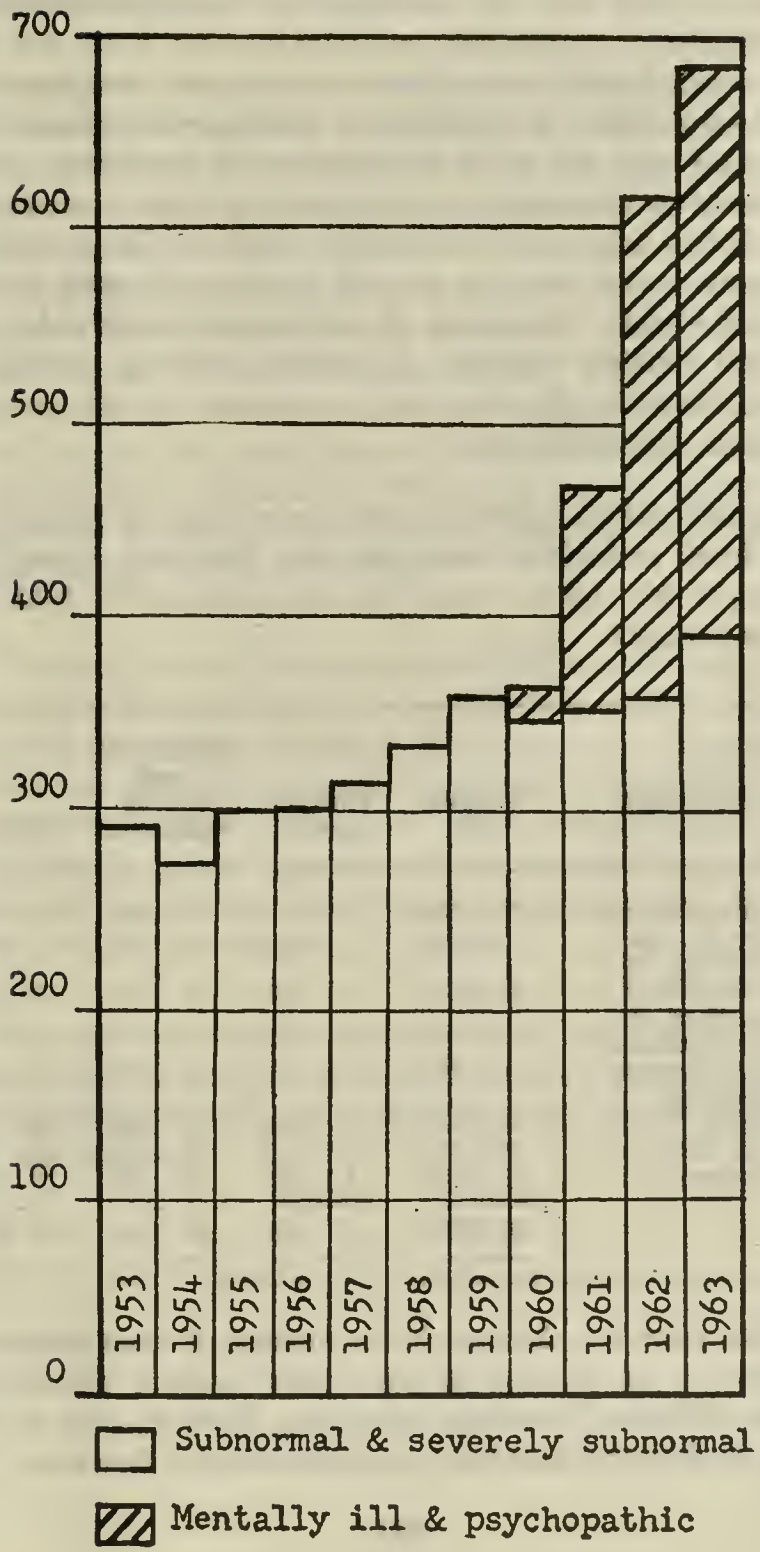
The ten year plan for the development of the health and welfare services lays down a broad pattern and is progressively becoming effective. Greatly improved facilities for training the mentally subnormal in particular, are emerging and residential facilities to help the resettlement or retention within the community of a wide range of mentally disordered persons will soon be available. All these are directed towards support and service at a personal level to the individual and the family by the general practitioner, the social worker and the nurse working as a team and mobilising the efforts of all the statutory and voluntary agencies.

The year under review was the first complete year during which the mental health domiciliary service was manned entirely by full-time all purpose mental welfare officers. When the Mental Health Act, 1959, came into operation towards the end of 1960 and

imposed a statutory duty on local health authorities to provide preventive and aftercare services for the mentally sick in the community, the area of this form of support was unknown. That this service has developed speedily and effectively in close association with the hospital and general practitioner services is shown by the following graph which illustrates the total number of cases receiving support from the domiciliary mental health services in their own homes at the end of each year from 1953 to 1963.

Mental Welfare Officers

Domiciliary Case Loads at 31.12.1963



It will be seen that whilst there has been a slow but steady increase in the number of subnormal and severely subnormal patients receiving help, the corresponding figures for mentally ill and psychopathic patients has risen from 0 to 292 in just over three years. Again it will be noted that the total case load has almost doubled since 1959. It is difficult to forecast with accuracy what the ultimate need will be in the provision of domiciliary services for the mentally disordered in the community. Many factors affect this, including advances in treatment, trends in the incidence of the various mental disorders, as well as the community attitudes mentioned above. The extent of the problem in the elderly age group will certainly increase. Reasonable forward provision is, however, made in the ten year programme for the necessary adjustments in establishment.

The table which follows analyses the referrals of cases coming to the local authority's notice for the first time during 1963 according to their source, the corresponding figures for 1962 being shown in brackets.

Source of Referral	Mentally ill	Psycho-path	Subnormal and severely subnormal	Total
General Practitioners ...	71 (59)	— (—)	1 (3)	72 (62)
Hospitals—on discharge from in-patient treatment ...	68 (124)	1 (3)	9 (8)	78 (135)
Hospitals—after or during out-patient or day treatment ...	38 (26)	— (2)	1 (2)	39 (30)
Local education authorities	1 (—)	— (—)	23 (39)	24 (39)
Police and Courts ...	10 (2)	— (—)	2 (3)	12 (5)
Other Sources	21 (18)	1 (1)	6 (16)	28 (35)
	209 (229)	2 (6)	42 (71)	253 (306)

While there is a decrease in the number of cases referred for the following up services by the mental welfare officers from hospitals following in-patient treatment, there is also a small increase in those referred from out-patient or day treatment. The

latter figure is gratifying and I can only hope that the former reflects a decrease in the severity or seriousness of the cases admitted in 1962 for treatment.

During the year pilot schemes were introduced in selected areas both in East and West Cumberland, in which Mental Welfare Officers were seconded to general practitioner group practices. These seem to be working well and apart from providing the closest possible contact between the family doctor and the local authority's social workers has resulted in many more requests for preventive social work from the practitioners concerned. Subsequently when the Sub-Committee of the Standing Medical Advisory Committee (Gillie Committee) made its report and recommendations on "The field of work of the family doctor", it was pleasing to see that in the opinion of the Committee, "Review of the psychiatric content of a practice by the doctor and (mental welfare) officer together at regular intervals can be very helpful".

The family doctor being in clinical charge of the patient when at home it is the duty of the local authority to support him to the full whilst the patient remains in the community. Experience to date suggests that this can best be achieved by secondment of the Mental Welfare Officer to the service of a number of family doctors. The further the field of operation of any particular Mental Welfare Officer can be governed by the areas of practice of a number of general medical practitioners, the better.

The table below shows the number of occasions when it has been necessary to apply the provisions of Part IV of the Act relating to compulsory admission procedures since the Mental Health Act came into operation.

Part IV Admissions

Section	1960 (November and December only)	1961	1962	1963
25 ... (For observation)	16	53	51	31
26 ... (For treatment)	5	25	28	21
29 ... (For observation in emergency)	2	31	56	75

Concern has been expressed nationally at the increasing use of Section 29 procedures to secure the compulsory admission of a patient to hospital for observation on the recommendation of only one doctor—usually the family doctor. Local figures since the Act came into effect confirm that trend. It will be seen from the table that whilst the total number of patients admitted for observation (Sections 25 and 29 together) shows no great fluctuation, the proportion of patients who enter hospital by means of the single doctor procedure of Section 29 has almost doubled in two years.

There seems no doubt but that it was the intention of the Mental Health Act that this Section 29 should be reserved for truly emergency purposes. Perhaps its somewhat extended use stems partly from the physical difficulties of one of the doctors with "special experience in the diagnosis or treatment of mental disorder" in travelling long distances to visit patients at home in order to apply Section 25. This "qualification" is applied at present almost exclusively to hospital board consultant psychiatrists, except as far as subnormality is concerned. The inclusion of a few more general practitioners who were suitably experienced and willing, on this expert panel may make a significant difference to the situation.

Preventive and supportive measures for those mentally frail residents of Part III establishments or supported independency dwellings continue to be provided by the Mental Welfare Officers

through regular contact with the residents, superintendent, matron or warden. Linked to the services of the general practitioners and the psychiatric and geriatric consultants this has, I believe, enabled the difficulties which sometimes arise with old people who exhibit mental disturbances to be dealt with promptly, and usually permits the patient to remain in the community of the Home without deteriment to the group.

Training Centres

(a) **For Juvenile Subnormals.**

The two full-time junior training centres at Whitehaven and Wigton which together provide facilities for the training of 90 juvenile subnormals, continue to meet the demand for the whole of the administrative area. A small percentage of the trainees, because of the extreme isolation of their homes in this widely scattered county, have to be boarded during the week-nights of school terms at the Orton Park hostel, so that they can participate in full-time training, and the work of this unit is described later.

The volume of provision being already adequate, the advance at present under way is towards improved conditions of training. A new centre will be opened early in 1965 at Hensingham to replace the present Whitehaven centre. This new centre incorporates the latest developments in the field and its many advantages are keenly anticipated. Similarly at Wigton, an extension to the present purpose built centre is planned for completion during the 1964/5 programme, not primarily to provide extra space but so that a more efficient grouping of the children will be possible.

The methods applied in training today have advanced considerably when compared with those of even 10 years ago. From simple day care the training has assumed greater similarities to the methods of nursery schools and adapted educational techniques based on active experience underline much of the work. The development of facilities in "special care units" to help the grossly handicapped (often physically as well as mentally) is prominent in our forward planning. I think it is true to say that given properly designed accommodation and staffing at a relatively enhanced rate, almost any mentally handicapped child, no matter how severe or

multiple the disabilities, could profit by attendance at a junior training centre. The training of this type of child will place increasing demands on the service because more are surviving the first few weeks and months of life and are ultimately growing into adults in spite of severe physical and mental handicaps. Units for "special care" must, therefore, be developed, not only that the child can be given the opportunity of training towards a happier and less restricted life, but also to afford relief to those members of the family upon whom is placed the physical burden of providing the care which is demanded by such a child in the home environment. As a Local Health Authority it is our duty to lighten that burden by bringing into play all the facilities at our command. There is ample reward, however, in being able to keep such a child in his own home, and permanent custodial care in hospital, which seemed to be the only answer until a few years ago, is now increasingly regarded only as a last resort, when the strain within the home becomes intolerable.

(b) **For Adult Subnormals.**

At the time of writing the first purpose-built training centre in Cumberland to cater specially for adult training needs, and which provides 50 places in the first phase, is in course of erection, and should be ready for occupation early in 1965. In the meantime the temporary premises which were opened for this purpose at Meadow View House have proved to be a most useful supplement to the scheme of training for the subnormal. On 18th February, 1963, 9 male and 11 female adolescent or adult trainees were transferred from the centre at Flatt Walks, Whitehaven, to Meadow View House, and by the end of the year the numbers on the register at the adult centre had increased to 34 (19 male and 15 female) largely by the intake of young adults for whom training facilities had not previously been available.

This interim measure, although somewhat limited in scope by deficiencies which are inherent in an old building not designed for its present usage has, nevertheless, been invaluable. It not only supplies extra space separate from the junior centre where an adult workshop atmosphere could be created (as distinct from the school atmosphere and disciplines of the junior centre) but also

permits the junior centre to revert entirely to its original purpose. It has been noticeable not only to the staff but also to delighted parents how relatively quickly those adolescents who were transferred from the junior training centres have matured under the more adult conditions which are fostered at the adult centre.

Mr. Lace returned to duty and was appointed Supervisor of the centre on the successful completion of the year's diploma course organised by the National Association for Mental Health for staffs of adult training centres. The success of this temporary unit to date augurs well for the future. At the same time it has provided an opportunity of overcoming some of the teething troubles which are to be expected when a new venture is undertaken and the move to the modern purpose-built centre at Distington is eagerly awaited.

Following visits paid by myself to other adult centres, towards the end of the year my Deputy, the Mental Health Officer and the Supervisor of the adult centre, visited a number of well established adult training centres. From their observations and in confirmation of my own experiences there appears to be a wide variation in concept as to the proper function of these units and in consequence widely differing techniques are applied. On the one hand some adult training centres are virtually sheltered workshops providing "occupation" within very restricted fields, the main object being to produce goods either for sale or in fulfilment of a contract. At some such centres there appears to be little, if any, attempt to continue the social education of the trainee to fit him for a fuller life in the community, nor is any real effort made to place trainees in outside employment. It is significant, I think, that in those centres where the policy is directed more towards the betterment of the social efficiency of the trainee, and where the main purpose of training is to equip the subnormal for open employment, the practical skills exhibited are of a higher standard than at the centres which concentrate more on production figures.

I suggest, therefore, that the emphasis of training in our adult training centre should be towards fitting the trainee for open employment, and as the difficulty in finding employment for a subnormal lies as much in the social sphere as in lack of skill, the training should primarily be geared towards making the trainee

completely acceptable in the community. Graduated training in a variety of skills can also be undertaken but the objective of training in manual skills should be to teach continued application and concentration at the job in hand and an ability to work effectively as a member of a team, rather than to discipline the trainee solely towards high production figures.

In the course of this year's review of the ten year plan for the development of the health and welfare services, the proposed provisions for the training of adult subnormals fell short of the figure suggested by the Ministry of 0.65 places per thousand population, and after careful thought the original plan was amended to provide a further centre in East Cumberland. Premises at present owned by the Council and which could easily be adapted to training centre purposes at little capital cost should become available in three or four years' time.

(c) **Parents' Association.**

The Parents' Association which came into being in 1960 at Whitehaven continues to flourish. Meetings are held at monthly intervals (excluding the midsummer months) in the junior training centre, and whilst the Association is run by the parents themselves. the staff of the centres and the Mental Welfare Officers give their support. Speakers on various topics of general, though often relevant, interest are arranged, and in the early summer an enjoyable evening was spent at Orton Park.

In February, and as a result of money raising efforts, a filmstrip and slide projector with a daylight screen (which avoids the necessity for blacking out a classroom) were presented for use at Whitehaven by the Association. For this we are most grateful—the apparatus has proved to be a most useful aid.

Residential Accommodation

(a) **For Subnormals.**

The hostel for junior subnormals at Orton Park is now well established, having been in operation since April, 1959. Indeed. without it, there would have been a number of children who. solely

for geographical reasons, could not have received regular training at a junior centre. Cumberland has been able to claim for nearly five years that any subnormal child within its million acres could be offered full-time training at a day centre, and this, of course, would have been quite impossible without some form of hostel facility.

Last year I reported that whilst it was reasonable to expect that some extra benefit might accrue to those children who whilst in attendance at a day training centre were living in a community which provided ample opportunity for social experience and development, assessments did not provide evidence that the rate of social maturation was any greater among those children who boarded at the hostel and received training at the Wigton Junior Centre when compared with those attending the same centre from their own homes. Towards the end of the year, in the light of this experience and coupled with the expense of maintaining the hostel on a full-time basis in spite of considerable under-occupation each weekend and throughout school holidays, it was decided to orientate Orton Park to a part-time establishment which would remain open only when needed to enable children from the outlying areas to attend the junior training centre at Wigton. Orton Park now opens only from Monday to Friday during the school terms (with mostly part-time staff) and staffing costs in particular, which formerly accounted for about 60% of the total expenditure on this unit, have been considerably reduced.

It seemed at one time as though this provision might later prove to be inadequate and it appeared that a second hostel, probably in the west of the county and linked for training purposes to the Whitehaven Junior Training Centre, might be needed. Further thought and reappraisal of the total situation now leads me to the conclusion that it does not seem necessary to supplement the present accommodation. Indeed I hope that it may be possible to develop small "family unit" type homes within fairly easy reach of the junior training centres, each catering for 6 or 8 children. This follows a similar line of development to that which has evolved in Children's Departments, and I also feel that part-time "boarding out" of some subnormal children is well worth a trial if suitable foster parents can be found. Either of these schemes

or some combination of them would achieve the desired objective of enabling training to be given to children from the more remote rural areas and at the same time secure even closer integration with the community than is possible at the present hostel.

(b) **For the Mentally Ill.**

Local Health Authorities, whilst anxious to do all in their power to implement both the letter and the spirit of the Mental Health Act, 1959, have varied thoughts, many misgivings and some apprehension about providing rehabilitation facilities in hostels for those who have been mentally sick. There is, as yet, little experience in this country of hostel provision for the mentally ill. The extent of need is difficult of any accurate assessment. However, in consultation with the psychiatrists who would in general make most of the recommendations for this form of care, a great deal of thought and planning has gone into the project for a 17 bedded hostel which should be ready in the spring of 1965. I am entirely satisfied about its location in Whitehaven, being within easy reach of both bus and railway stations and all the amenities of one of Cumberland's major towns. This is in an area which also offers a much wider range of job opportunity than does the greater part of rural Cumberland.

To give the greatest flexibility of use the sleeping accommodation is arranged mainly in single rooms, but a few double rooms, which offer a great measure of privacy to both occupants, are also included. Because the full extent of the need for this form of support is not yet clearly defined, the planning of the new hostel makes it possible to up-grade the capacity from 17 to 30 residents with minimal capital expenditure. I am at present consulting with the psychiatrists and the general practitioners' representatives on the detailed arrangements for medical and general supervision of the residents.

This project offers a real challenge if it is to achieve success, and one which calls for the greatest measure of co-ordinated team work between the general practitioners, the psychiatric consultants, my own medical and social work staffs, officers of the Ministry of Labour and the National Assistance Board and the organisations offering voluntary services.

Hospital Accommodation

There must be few local health authorities which encounter as little difficulty as Cumberland in securing hospital accommodation when it is needed for the mentally disordered. Rarely is there a delay of more than twenty-four hours before a bed is made available for psychiatric treatment either in a small psychiatric unit such as forms part of the West Cumberland Hospital, or in the new admission unit or the longer stay accommodation at Garlands Hospital. The peripheral out-patient clinics which are held by the hospital consultants carry out both diagnostic and follow-up functions, and the easy access to these clinics which is afforded to the general practitioners and my own social workers (and supplemented in this context by the secondment of mental welfare officers to practitioner groups) helps considerably in ensuring that in-patient treatment is quickly available when this is indicated. Mounting pressure at the West Cumberland unit has necessitated some extension and psychiatric accommodation will be increased to 30 beds for short stay patients by the middle of 1965.

Cumberland waiting list for hospital accommodation for the subnormal and severely subnormal numbered 33 patients at the end of the year, but only one of these was regarded as urgent and the patient has since been admitted to Dovenby Hall Hospital. For some years there have been varying degrees of over-crowding in the wards which cater for different grades of subnormality in both sexes, but the most severe and persistent over-occupation has been in those wards in which there is the smallest turnover of patients—the low grade children's wards. Dovenby Hall Hospital's total accommodation is to be increased by about 60 beds during 1965 by the building of new wards. Once more I must place on record my appreciation of the help given by the Medical Superintendent (Dr. Ferguson), especially on those occasions when an emergency arises which demands the hospitalisation of a subnormal for a short period. With the further development of the Local Health Authority's training facilities, particularly for adolescent and adult subnormals, I look forward to the possibility of arranging, in consultation with Dr. Ferguson, for the discharge of selected patients from hospital to their own homes with full community support, including the continuation of training at a full-time day centre.

Social Centres and Clubs

The two social clubs for the mentally disordered which continued to operate on Monday afternoons in the Local Health Authority's clinic and on Wednesday evenings at the Junior Training Centre (both at Whitehaven) were supplemented by the opening of another evening club at Workington on Monday evenings. These clubs do not claim to be therapeutic, though it cannot be denied that they have some value in this direction. The principal aim is to provide the opportunity of companionship to those who find it difficult to make contact with others and by so doing to help restore their self confidence. Whilst the members are encouraged to run these organisations for themselves, a great deal of discreet support is given by the Mental Welfare Officers who indirectly are able to see the patients regularly under conditions differing from the home environment.

Training and Recruitment

It has been the Council's policy for some years to ensure that the staff which it employs to man its services are given every opportunity of undertaking the type of training most appropriate to their needs.

So far as the training centres are concerned, Mr. Lace returned to duty in July, having successfully completed the special one year's course of training for staffs of adult training centres offered by the National Association for Mental Health. An assistant housemother at the hostel for subnormal children, was accepted for a similar course for staffs of junior centres and commenced her studies in September but without financial assistance from the Local Health Authority.

With the ever increasing emphasis on the care of the mentally disordered in the community with which is inevitably linked a statutory duty to provide centres for the training of those children found to be "unsuitable for education at school" it has become necessary to take stock of our methods of recruiting staff for this service. In so doing it is recognised that the potential of the subnormal for learning through educational techniques is much greater than was thought to be the case when "occupation centres" were

first established. Following this reorientation of function I feel it is essential to ensure a steady flow of adequately trained personnel into the training centres. A trainee scheme was approved during the year and will commence in September, 1964, by the appointment of one trainee to each of the junior training centres. Candidates are not admitted to the approved training courses until they are at least 18 years of age and in addition to specific educational attainments should have had some experience in the handling of children. Because of these limitations, school leavers who would have been eminently suitable for this work are lost to the service by taking up other careers immediately on leaving school. Following the recommendations of the Scott Committee, trainees under the local trainee scheme will be supernumery to esablishment so that they can be given preliminary training and supervision in all branches of the work without having specific commitments for any particular group within the centre. They will be recruited from school leavers, having a basic minimum of three passes in the General Certificate of Education at Ordinary Level, and the appointments will be regarded as probationary for the first term, so that an assessment can be made of the trainee's suitability for further training. Preliminary in-service training at the junior training centres will be supplemented by arrangement with the Director of Education by short periods spent in nursery, infant, and junior schools, and possibly at the special schools for the educationally subnormal. They will be required to attend colleges of further education on one day and two evenings each week for cultural and craft subjects. As soon as practicable after attaining the minimum age of 18 years the trainees will be seconded to one of the diploma courses of the National Association for Mental Health, and on successful completion of the approved course will return to the service as qualified assistant supervisors. This seems to be a sound policy aimed initially at recruiting the best material, which in the long term should provide a steady flow of trained staff to this expanding service.

Miss Welch returned to duty in September, having completed her training as a psychiatric social worker under the Council's scholarship scheme and having been awarded the Certificate in Mental Health of the University of Manchester. She was promoted to the post of Senior Mental Welfare Officer which became vacant

at the end of November when Mr. Mayoh resigned to take up another appointment. I hope eventually to be able to recruit a professionally trained social worker to act as team leader to the social work field staff in each of the three proposed administrative areas of the County.

The Council for Training in Social Work, which was established under the Health Visiting and Social Work (Training) Act, 1962, is now getting into its stride in helping to meet the great shortage of trained social workers in Local Authority employment. The number of two year courses for training in general social work which leads to the Council's Certificate in Social Work has increased from four in 1962 to ten at the present time, and this number is expected to rise to fifteen by the autumn of 1964. One officer was seconded to one of the courses in September, 1962, and the departmental establishment was increased by one post of trainee mental welfare officer during 1963, the trainee being seconded to a full two years course beginning in September, 1963. It is essential if the growing needs for trained social workers in the field are to be met, that this secondment of suitable candidates continues for some years to come. At the same time it is pleasing to note that the Council for Training in Social Work also proposes to establish as an emergency measure during the next five years a number of one year full-time courses so that those already in service may have the opportunity of reinforcing their experience with a shortened course of full-time training leading to a recognised qualification (the Council's Certificate in Social Work).

Following a recommendation of the General Nursing Council and with the approval of the Ministry of Health, a Nurse Education Committee has been established at the Garlands Hospital, and the Mental Health Officer accepted an invitation to become a member of that Committee. Its function is to correlate teaching in the training school, on the wards and outside the hospital and to make appropriate recommendations to the Hospital Management Committee and so eliminate approaches through a number of channels before fully representative discussion has taken place.

As part of a Council of Europe Fellowship Study, and at the request of the Ministry of Health, an Assistant County Medical Officer, from Co. Offaly, Eire (Dr. John Humphrey), spent the

month of October in Cumberland to observe inter alia the part played by the Local Health Authority's services in the control of mental ill health and the follow-up and aftercare of the mentally disordered.

Members of the staff have attended various short refresher and follow-up courses during the year and staff conferences for mental welfare officers and for the staffs of training centres and the hostel have been held at about quarterly intervals throughout the year. These provide an informal opportunity of discussing the development and improvement of the service and of exchanging information and ideas.

HOME HELP SERVICE

The Home Help Service continues to expand, and while there has not been any dramatic development during the year there have been some administrative changes which have improved the organisation of the work as a whole.

At the end of January, 1963, the records of home help cases for West Cumberland were transferred to the Whitehaven office, where clerical help was made available. Thereafter all matters connected with the work, both administrative and operational, have been dealt with locally.

The reorganisation has been a great advantage to the assistant nursing officers responsible for the day to day running of the home help work, each in their own area. They can now deal personally with any problems which arise, saving time and ensuring a quick result.

When the areas were divided the number of householders and home helps was as follows:—

	House-holders	Home helps
Southern area:—		
Comprising Whitehaven, Ennerdale Rural, Millom and Millom Rural	234	74
Western area:—		
Comprising Maryport, Cockermouth Urban and Rural, and Workington	195	40
Northern area:—		
Comprising Border Rural, Wigton Rural, Penrith Urban and Rural, and Alston Rural	259	113

It is interesting to note that the average number of cases per home help per week in the three areas is as follows:—

Southern Area	4
Western Area	5
Northern Area	2

A little investigation soon demonstrated the reason for this. It was found in the urban areas the home helps were able to help more households each morning and therefore considerably more during each week. For instance, one home help may visit two or three houses in one street thus eliminating a considerable amount of travelling time; there are more frequent bus services in the urban areas, and very few houses are isolated. In the northern predominantly rural area the picture is very different. Geographically the area is equal to the southern and western together, although the population in the three areas is much the same and stands at about 75,000 in each. It was found that here, on an average, the home helps visit only the same one or two households each day. Owing to the isolation of a number of the villages, or the poor bus service between the villages, it is often necessary to employ a home help locally who may be attending only one household, and others who may travel between villages which is time consuming and only allows of one or two households to be visited. It has been found also that the home helps are often only available for part-time work in the area in which they live. In spite of the isolation factor, and the very limited bus services, it is gratifying to state that there are only five households to whom we were not able to supply help. The development of the mobile home help service will go a long way to eliminate these in the future.

With a view to solving the problem of meeting the need where it exists in isolated households, a scheme was started for mobile home helps. This was advertised in the local papers inviting persons with their own transport to apply, and a retaining fee would be paid when there was no work available. Two suitable applicants were appointed, one with a car and the other with a bicycle; since then, the one with the car has proved invaluable in the amount of work she has been able to do in isolated communities. The home help with the bicycle lives in a very rural area, and while, of course, the distance she can go is limited, she too has fulfilled a need. Amongst the regular home helps there are also two with cars, both working in rural areas, who can undertake more than one or two cases per week.

The Home Help Service continues to increase and this year 1,017 households have been helped. As before, the main increase is in connection with those over 60 years of age. There has also been some development in the care given to families where the mother has been unable to cope, and one or two of the home helps have done invaluable work in helping with rehabilitation. One family, where there were nine children with the mother ill and finding it difficult to manage, was supplied with a home help after mother returned home from hospital. The conditions in the home had deteriorated beyond the stage when she could manage to put is right herself. The wall-paper was torn and dirty, and the house generally neglected. The continual cooking and washing for this large family was an unending problem. After the home help had been there for a period it was most encouraging to find that there was a general improvement in the house, the kitchen had been papered and painted, and the mother was working with the home help who was giving her the utmost encouragement. The home help's hours have been gradually reduced, and the improvement has been maintained. With such a large family this mother will need a certain amount of help for some time to come. Help was given to another family where the mother was mentally ill, and the condition of the house had so deteriorated that the best solution seemed to be to arrange for a home help to assist the family regularly. When help was supplied the mother's condition began to show some improvement and is being maintained, but obviously help will need to continue for quite a long time. In another household, difficulties arose due to the change in personality of the householder associated with a serious degenerative illness. In this case every home help in the district has been in to help at some time but each feels unable to continue indefinitely, and the only solution seems to be a rota of home helps. There is no hard and fast rule, each individual case presents a different problem.

During the summer months meetings for home helps were again held in various parts of the county—Wigton, Keswick, Penrith, Whitehaven, Workington, Alston and Carlisle. The home helps were fully aware of the typhoid outbreak in this country and in Switzerland so the subject of the talk was "Food Poisoning", followed by a film strip on "The Life of the Fly" and a flannel-

graph on "Fighting Germs by Degrees". This provided very interesting and instructive meetings. In addition time sheets, arrangements for sickness and holiday, and general problems in the work were discussed.

The visiting necessary to keep this service running smoothly is very considerable and time consuming. During the year the nursing officers have paid 1,619 visits. The district nurses and health visitors in the course of their work have helped in visiting the households and seeing the home helps from time to time; their visits during the year have amounted to 6,581. They have been most helpful in dealing with problems on the spot, and have written to say how invaluable the home helps are, often doing more than is expected of them in their own time. Their devotion to duty during the hard winter months of 1963 was most praiseworthy; many home helps walked miles in the snow to get to their old people marooned in their cottages. One nurse reports, "We have some wonderful home helps in this area, one or two especially more than willing to 'go the extra mile' in the houses in which they work. They decorate in their own time for the old folks, sometimes even providing the paper and paint themselves where the householders cannot or will not provide them. The home helps are truly worth their weight in gold."

The increase in the number of householders helped, naturally, has its repercussions on the financial side, and the cost of the service this year will be at least £42,000. During the year it was found necessary to increase the standard charge from 3/8d. to 4/- per hour.

In September, Miss Watson, Assistant Nursing Officer, attended the Institute of Home Help Organisers Annual Weekend School held at Buxton, the theme being "The future place of the Home Help Service in the Community". There were various subjects discussed and lectures given, which included "New Concepts in Community Care", "Can work study technique be applied to the Home Help Service, Social Worker, Personnel Manager, or Administrator?" A popular session was a discussion on "Liaison and Co-operation".

The home help has become an integral part of community care. The increasing number of those of pensionable age who are helped whether they are living in their own homes, flatlets or grouped bungalows where there is warden oversight, continue to give abundant evidence of this. With the prospect of an increased number of elderly, local authorities will need to budget even higher to enable the home help service to meet the increasing demands, and indeed their ever increasing needs.

Home helps on register at 31st December, 1963:—

Southern area	64
Western area	39
Northern area	137
	240

Householders receiving assistance at 31st December, 1963:—

Southern area	234
Western area	196
Northern area	240
	670

During 1963, 1,017 households were helped as shown in the following table:

	Aged 65 or over on first visit in 1963	Home help to households for persons aged under 65 on first visit in 1963. Chronic sick and tuberculous	Mentally disordered	Maternity	Others	Total
	1.	2.	3.	4.	5.	6.
No. of cases ...	834	55	11	66	51	1,017

WELFARE SERVICES

No less than in the various departments of the health services have the welfare services throughout the county been highlighted by the publication of the Ministry of Health "blue book" on "Development of Community Care". For the first time there has emerged a comprehensive account of the plans of every local health and welfare authority and the beginnings of standards of provision of services. I am glad to say that in welfare services Cumberland's proposed provision in the ten year programme compares very favourably with any other authority and shows that a high standard of provision in terms of both residential accommodation and field welfare services has been envisaged for the county. By the time the "Development of Community Care" was published the first review of the Authority's ten year programme was, of course, under way and in welfare services this contained a slight upward adjustment of the number of residential places in old people's homes as well as one further post of social worker and provision for a further handicapped persons centre in the east of the county, at Station View House, Penrith, when this ceases as an old people's home; also the present junior training centre at Whitehaven will be adapted for the same purpose when its present use transfers to the new junior centre. It was very noteworthy that the above national document showed that only 11 new homes for younger handicapped persons were being provided in the country and that Cumberland was one of those authorities with plans of this kind.

A very important move forward has been made during the year in the matter of liaison with voluntary organisations working for the elderly and in the integration of their excellent efforts with the work of the department staff. The survey of a sample of persons over 75 in the county has been completed and at the time of writing this report is being analysed in preparation for publication. It is already apparent that many interesting revelations will be contained in these results.

Homes for Elderly People

As previously I use the above heading not only to refer to the authority's provision of residential accommodation within its

responsibilities under Part III of the National Assistance Act, but to cover the whole matter of the varying situations in which elderly people spend the later years of their lives. Indeed it seems increasingly clear that while much attention inevitably and quite rightly focuses upon old people's Homes, the major field of provision of services for the future will have to be considered in terms of elderly people living on their own, with relations, or in conditions of supported independence in grouped dwelling arrangements with warden supervision. It is in such a context that community care of an ageing population must today be considered. It was also in this very important connection that very useful discussions took place during the year with the housing authorities. These discussions ranged over the whole field of housing provision but a very important aspect was the housing of the elderly and handicapped, including the building of grouped dwelling schemes where a sense of independence could be maintained while all the necessary services, statutory and voluntary, were unobtrusively mobilised in support. The discussions were very frank and I believe mutually helpful in promoting the understanding of the issues involved in welfare as well as the actual building programmes of the housing authorities. I am very glad to say that at the time of writing this report four grouped dwelling schemes are in operation, two more will very soon be operating and a further eight are planned for the next three years. This will give by 1967 a total of over 300 places in this type of accommodation, which is undoubtedly in my opinion a critical form of provision for the future. It is interesting to note that by the same time there will be a number of the order of 480 places available in old people's residential homes. I give below a little more detail on both the residential homes and the grouped dwellings providing conditions of supported independence.

The general care and welfare of elderly people living alone or with relatives in the community remains, however, a major responsibility and a challenge to both the statutory and voluntary services which are available. The part played by the domiciliary nursing staff of the health and welfare department has been and must continue to be an integral and highly important branch of this work. In 1963 the number of cases over 65 years of age

nursed at home by the domiciliary nurses was 2,933. This constitutes 48% of the total number of cases nursed. It will be quite apparent therefore that for every one patient who receives care in residential accommodation, or indeed in hospital, there are many with illnesses or infirmities of a long or short term nature requiring domiciliary nursing service in a year. Increasing frailty and infirmity amongst the elderly wherever they may reside must be faced as the order of the day for the future, and the firm integration of nursing staff, welfare officers, and voluntary workers, must develop rapidly. In this connection I draw attention again to the details given earlier in this report in connection with the nursing services concerning the close attachment of health visitors and certain district nurses and mental welfare officers to group practices. This has ensured some further progress towards the ideal of the domiciliary team led by the family doctor and supported systematically by these various workers. Several of the family doctors who have recently had health visitors seconded to their practices give as their first comment on their services the great help that they have been with the elderly group of their patients. It is here also that there is a field of co-operation by the health visitor and district nurse which can most appropriately operate on a practice basis.

The role of the voluntary organisations is rapidly emerging more clearly and I give a brief account below of the measures adopted during the year to ensure that these services develop in a coherent pattern alongside the authority's domiciliary and residential services.

Supported Independency Schemes

Two new schemes were completed and occupied during the year; one by the Cockermouth R.D.C. at Papcastle and the other by the Border R.D.C. at Dalston. Accommodation provided under these schemes is now as follows:—

Keswick U.D.C., Derwent Close, Keswick ...	20 flatlets
Wigton R.D.C., Western Bank, Wigton	20 bungalows
Border R.D.C., Barras House, Dalston	24 flatlets
Cockermouth R.D.C., Castle Gardens, Papcastle	15 bungalows

The policy of providing this class of accommodation has been adopted by every district council in the county.

Two further schemes will be completed in 1964, one by the Border R.D.C. at Brampton providing 20 flatlets and another by the Alston R.D.C. providing 10 flatlets in association with the Old People's Home. By the end of 1965 it is expected that schemes will have been completed as follows:—

Penrith U.D.	20 flatlets
Cockermouth U.D.	20 flatlets
Longtown, in association with an Old People's Home	10 flatlets
Workington	24 flatlets
Ennerdale R.D.	20 flatlets
Penrith R.D.C., in association with an Old People's Home	10 flatlets
Hensingham	20 flatlets

The two remaining schemes of Maryport Urban and Millom Rural Districts will, it is hoped, complete the coverage of the whole county by 1965/66.

No aspect of welfare work illustrates more vividly than do these grouped dwellings, the complexity of the growing problems of the ageing in the population, or the necessarily dynamic approach and constant rethinking which they demand. The tidy concept of the elderly person moving at increasing stages of infirmity from his or her own home to supported independency dwellings, then to residential accommodation, and finally to a long stay hospital bed, just does not fit the facts of life at this end of the age spectrum. It is quite apparent that in many cases if the happiness and contentment of an elderly person is to be preserved (and this can be the only worthy aim of our services) the services will have to be extended to the limit to allow of an individual ending his days in the surroundings to which he has become well adjusted and in which he wishes to remain. This is no new problem, but it has been highlighted in the past year in the setting of these admirable grouped dwellings where the warden's role has, of necessity, come under close scrutiny. If an elderly person living in, say, a flatlet in one of these schemes requires considerable help,

including some night attendance, and is quite unwilling to move to an old person's home, there exists a very real challenge to the statutory and voluntary services locally if a very undesirable degree of involvement on the warden's part is to be avoided.

In association with one of the schemes a very commendable effort by the British Red Cross Society has been made to ensure that at any time one or more members of the team of voluntary helpers would be available for assistance by day, or if necessary by night, for a limited period. This is not designed to take the place of the help which relatives should and could in many cases give, but to close the gaps which inevitably appear when relatives live at a distance. The winter of 1963/64 not having been a particularly severe one, this service has not been tested too severely so far.

In the selection of tenants for these schemes I feel sure the district medical officer of health, who is also an assistant county medical officer, must play the leading role, and under the arrangements of area administration coming into operation during 1964 these schemes, along with the other welfare services, will have a new sense of belonging to an area whose unified health and welfare services are under the delegated direction of the area medical officer.

The problems associated with the concept of supported independence in grouped housing arrangements must, and will be solved, both on general sound principles of welfare and taking account of local situations and circumstances. This type of housing provision is undoubtedly a key one for elderly people for the future, and a growing awareness of this and interest in it by all the housing authorities in the county is most gratifying. It reflects a real sense of being "en rapport" with today's most forward thinking on the needs of the elderly.

Residential Hostels

As the inevitable increase continues in the number of elderly persons in the community, the demand for residential accommodation does, of course, increase similarly. The new homes at Workington and Egremont have been fully occupied during the

year, and with the fading image of the ex-Public Assistance Institution more applications have been received for admission into the homes. No new homes have been brought into use during the year, but building is proceeding at Alston and Brampton and should be completed by the end of 1964. It will be remembered that the Alston home contains 10 places and is directly associated with 10 grouped dwellings provided by the Rural District Council. At Brampton 25 places are being provided in the home. The changing community attitude to welfare generally is being reflected in the way in which voluntary organisations and others, not necessarily associated with any particular organisation, are visiting and taking an active interest in the old people in the homes. Concerts, film shows, parties of various kinds, have been staged by voluntary helpers quite frequently and outings arranged throughout the year. The steady increase in this type of activity and in the build-up of personal visiting and friendship is undoubtedly enriching the lives of the residents in the homes. In most homes arrangements have been made for a handicraft instructor to visit, and the ladies particularly have become very interested in the occupations provided. A greater sense of belonging is steadily being built up and more residents are introducing personal items into their rooms. It is very gratifying to see individuals "homes" being established within the larger unit.

The introduction of a picture library service by the British Red Cross Society and local art groups, including schools in some areas, has created great interest. The residents themselves select the pictures to be hung.

Luncheon clubs at Parkside, Maryport and Castle Mount, Egremont, are now firmly established, and the elderly attending such clubs mix freely with our own residents. At the time of writing this report commencement has been made with day centres. The first of these is at Richmond Park, Workington, where five people on the waiting list for admission to the home are now attending on a day basis. Not only do they share in all the activities and fellowship of the residents socially, but have access to bathing facilities, chiropody, physiotherapy and diversional occupations.

Miss Ross, Matron of Parkside, Maryport, makes the following very interesting contribution on the activities in that home:—

"Most of the ladies take a pride in their rooms, and make them look as homely as they can. One has made cushion covers for an easy chair, another brought with her a "Gay Box" filled with glass ornaments which hangs on the wall, together with pictures and plaques. It has been much admired by visitors, and the other ladies are beginning to imitate it.

On Thursday afternoons, Mrs. Melville comes to teach handicrafts to the residents, who compete with one another as to who can get the best results. This is very good for them when the number of visitors is not so great during the winter months.

A few ladies like to think they are useful and have their regular chores, for example, drying dishes, and dusting in the dining room and their own bedrooms, also the setting of tables. Some of the ladies make their own beds in addition. One lady makes firelighters with old newspapers to the extent that we have no need to buy wood to light fires. Another is very good at sewing and assists the staff with all mending and patching, although crippled with arthritis.

It is a harder task to get the men's interest, but since they now own a dog, two of them are very fond of exercising her and looking after her. One of these men is the general messenger boy for staff and residents. Another old gentleman acts as escort to three ladies from the lounge to the dining room and back again at each meal time.

Services are held by the Church of England on the first Sunday and by the Plymouth Brethren on the third Sunday of every month. Mr. Eckersley (C.E.) gives communion once a month, and Father Croft does likewise for the Roman Catholics. Mr. Thompson, lay preacher for the Methodists, attends on the second Wednesday of each month."

While the waiting list for admission to homes continues to grow, there is quite a number of old people who are living alone or who are left alone most of the day whilst members of the family are at work. By arranging for such to enjoy the facilities of a home as outlined above, there is no doubt that a very real need can be met and a further attack made on the problem of loneliness. The homes of the future will accordingly be planned with such additional needs in mind.

Mrs. Abbott, Matron of Castle Mount, Egremont, writes as follows:—

"I give below the social activities which are happening in Castle Mount regularly.

1. Luncheon Club—at the present time nine old people from Egremont are attending one day each week.

2. Meals on Wheels—24 meals are distributed in the Egremont district each week.

3. Whist Drive and Dominoes, for which prizes are given, are organised each week by the Egremont Inner Wheel Club. For those unable to join in, a raffle is held.

The residents seem to prefer spending some of their time doing the ordinary jobs around the Home—e.g., taking care of the house plants, washing dishes, being responsible for the distribution of the daily papers and letters and doing messages. One resident is embroidering chair backs for the lounges, and knitting and basket-work is being done. The more able-bodied residents like to help the staff generally with small tasks."

Arrangements were made for residents who so wished, to have a fortnight's holiday at The Towers, Skinburness. During the year staff complements have increased at the larger homes to provide night attendance and to meet the heavier demands on the staff due to the increasing age, frailty and physical handicaps of the residents.

The practice of sending matrons to courses arranged by the National Old People's Welfare Council continues. Two attended such courses during the year and two more will be going in 1964. I have no doubt about the considerable value of these courses in the orientation of the staff to the most up to date approach to the welfare of the elderly and the problems of caring for them in residential homes.

The Ministry of Health Principal Dietitian visited some of the homes during the year and contributed very helpfully with ideas on such matters as the selection of menus.

The following table of beds and occupancy emphasises the increasing demand for the accommodation provided in modern type homes. The statistics relating to available beds and age groups in these homes indicates the longevity of the residents in that out of 232 residents on 31st December, 1963, eight were over the age of 90, and 95 over the age of 80.

At 31st December	No. of beds provided			No. of Residents		
	Joint-User Establish-ments	Modern Type Homes	Total	Joint-User Establish-ments	Modern Type Homes	Total
1949 ...	375	—	375	235	—	235
1950 ...	375	—	375	238	—	238
1951 ...	325	—	325	243	—	243
1952 ...	325	—	325	217	—	217
1953 ...	325	19	344	201	18	219
1954 ...	325	19	344	219	19	238
1955 ...	263	69	332	188	57	245
1956 ...	263	69	332	189	70	259
1957 ...	242	69	311	188	65	253
1958 ...	242	87	329	193	88	281
1959 ...	252	108	360	199	99	298
1960 ...	215	146	361	174	132	310
1961 ...	215	146	361	178	132	310
1962 ...	117	230	347	93	208	301
1963 ...	117	230	347	112	222	334

Table of age groups in modern type homes.

Home	No. of Beds					AGE GROUPS OF RESIDENTS MALES						FEMALES						Total No. of Residents
	4 bedded rooms	3 bedded rooms	2 bedded rooms	Single rooms	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	
Grange Bank, Wigton— Opened 1.4.53	12	6	—	1	19	—	—	—	—	—	—	1	5	3	10	1	20	20
Derwent Lodge, Papcastle— Opened 1.1.55	8	6	4	—	18	—	1	7	7	1	16	—	—	—	—	—	—	16
Garlieston, Whitehaven— Opened 1.11.55	12	18	—	2	32	1	—	4	7	2	14	—	3	6	4	1	14	28
The Croft, Kirksanton— Opened 1.3.58	—	9	8	2	19	—	5	—	5	—	10	—	1	3	5	—	9	19
Parkside, Maryport— Opened 16.5.60	—	—	20	20	40	1	5	6	6	—	18	1	4	7	9	—	21	39
Castle Mount, Egremont— Opened 29.11.62	—	—	18	20	38	1	5	7	4	2	19	—	2	5	9	1	17	36
Richmond Park, Workington— Opened 10.10.62	—	—	18	20	38	3	3	10	6	—	22	2	3	6	4	—	15	37
The Towers, Skinburness— Opened 1.8.58	12	6	8	1	27	(—	—	—	—	—	—	—	—	4	1	—	5)	
						(3	1	5	4	—	13	—	1	2	6	—	*9)	27
Totals	44	45	76	66	231	9	20	39	39	5	112	4	19	36	48	3	110	222

By arrangement, a local authority may provide residential accommodation for a person ordinarily resident in the area of another authority, subject to the latter meeting the cost of maintenance where appropriate. Thus, on 31st December, 1963, accommodation was being provided in Cumberland homes for three men and two women on behalf of other authorities.

Similarly, one man and three women ordinarily resident in Cumberland were accommodated in homes by other local authorities.

Voluntary Work for the Elderly

In this field, which has already been touched on in various individual contexts, all of the major voluntary organisations in the field and many smaller ones, as well as numerous individuals, have contributed most admirably to the welfare of old people, and the means of liaison with the department's workers, which are described elsewhere in this report, are slowly but surely increasing in effectiveness.

I am grateful to Mrs. Ellwood, Old People's Welfare Organiser for the Cumberland Council of Social Service, for the following notes on her work. Since her appointment Mrs. Ellwood has proved invaluable in co-ordinating much of the voluntary work for the elderly, while at the same time contributing substantially to the matter of liaison with the department's work.

"Volunary organisations in Cumberland have never lagged behind in service to the aged and infirm and the housebound handicapped, and during 1963 it has been a great encouragement to me to see how appeals for a more concentrated voluntary effort have been met with sympathy and increased activity. Visiting, both of elderly people in their own homes, and in the residential homes of the County Council has shown a marked improvement. New visiting groups have been formed where none existed previously, and church organisations and other voluntary bodies have all combined to extend the scope of this service. This, together with the formation of new 'Over 60's Clubs' and the provision of activities within such clubs, luncheon clubs, transport and escort service, hospital aftercare and the large expansion of the meals on

wheels service, has made great demands upon our reserve of voluntary effort and energy.

For the first time there has been machinery set in motion for direct consultation between the statutory health and welfare authorities and the voluntary organisations. Seven area committees, each guided by its own district medical officer, comprising members of both statutory and major voluntary bodies, have proved a most effective means of pooling information on a two-way basis. Voluntary organisations have benefited greatly by these regular meetings with the medical officer, district welfare officer, mental welfare officer, district nurses and health visitors. They now have an informed knowledge of the work of each statutory department and of its place in the health and welfare services as a whole. They have been told how they can best use the industry and talents of their members and so are able to present these needs to their separate organisations more effectively. In reverse, the statutory authorities, whose knowledge of the available voluntary help was very incomplete, now know to which organisations they can apply for help with a particular service just how much assistance such an organisation is able to offer.

Acting as liaison between the statutory and voluntary organisations it has been possible to see progress being made, hand in hand, during the past year. The medical officers have encouraged and upheld existing voluntary services, at the same time helping to channel this work into line with the needs of the ten-year development plan. The voluntary organisations in their turn have responded to the utmost and deserve great credit.

To make voluntary effort more effective and to meet the increased demands which will be made upon it, skill in the application of such voluntary work will become part of an essential pattern. Training courses for voluntary workers are being held all over the county during 1964. We hope these will be attended not only by members of organisations, but by individuals who might like to give a little of their spare time to voluntary social work. They might like some guidance as to what opportunities there are for helping the lonely, handicapped or infirm, and just what this involves for them. A well informed, skilled volunteer on whom a

hospital matron, warden of housing scheme, or even an old person in her own home, can rely implicitly is of the greatest possible service.

If we can combine our skilled voluntary service with progressive statutory action, consult with each other as we have done during this year, then our joint efforts cannot but be successful."

The question of grants payable by the County Council to old people's groups has been revised during the year and these grants have been increased. Account is taken of the groups' funds in assessing an application for financial help, though equal thought is given to the place which the club occupies in the community, the possible need to expand to meet a growing membership, and the need in terms of furnishings, equipment, etc.

Outstanding amongst the domiciliary service provided mainly by voluntary effort is, of course, the meals on wheels service in which the W.V.S. play the leading role. The increase in this service over the past five years is quite fantastic. Comparing the financial years 1958/59 with the year now being entered, 1964/65, the service will have expanded one hundredfold. 300 meals approximately were delivered in the former year—it is estimated that 30,000 will be the figure for the latter. This takes no account of luncheon clubs mentioned previously. It is quite apparent without further comment therefore, how wonderfully the W.V.S. have risen to this task. I quote from the W.V.S. report on this subject as follows:—

"Meals on Wheels have increased throughout the county since April, 1963, and will increase further during the coming year. Generally speaking the County Council provide equipment and pay the cost of the meal less 1/- from the recipients, and the local district council meet the cost of transport. A number of services are now obtaining the meal from a County Council old people's home, and these meals are proving more suitable for elderly people than those obtained from canteens and schools meals kitchens. The County Council health and welfare department hope that in time all services will be able to draw meals from the old people's homes, which will lessen the costs of the service and also reduce W.V.S. book-keeping.

EGREMONT: A new service started on 9th October, 1963, with 14 old people receiving one meal per week; by the end of December, 23 old people were receiving one meal per week. The meal is drawn from Castle Mount Old People's Home, and Mrs. Abbott has been very helpful.

KESWICK: A new service started on 11th November, 1963. Approximately 24 old people are receiving two meals per week. During term time the meal is drawn from Lairthwaite School, and during the holidays Mr. N. W. Seal has agreed to make the meals in his cafe for 2/9d.

WORKINGTON: This service (the oldest W.V.S. meals round in the county) was reorganised in the summer. A second Hotlock was provided and each old age pensioner now receives two meals per week except where they have asked for one only) and the Hotlocks are also used for the Seaton (Cockermouth R.D.) rounds. The source of meals was changed from United Steelworks Canteen to Richmond Park Old People's Home in December, 1963. The Steelworks Canteen has been most helpful during the time meals have been drawn from there, but the meal provided by Richmond Park is much more suitable for old people and is much appreciated.

WIGTON: A new service started in September, 1963. Twelve old people are receiving two meals per week. The meal is drawn from Highfield House Old People's Home, and Mr. and Mrs. Howe have been most helpful over the organisation. Mr. Howe asked if separate containers could be provided for gravy and custard and two Thermos jars have been provided from County Council grant.

SEATON: This service started in March, 1963, delivering one meal per week to 12 old people. A second delivery was started in November and 12/13 old age pensioners now receive two meals per week. The source of meal was changed (with Workington) from United Steelworks Canteen to Richmond Park Old People's Home in December, 1963.

MILLOM: The number of recipients dropped a little in November and December as several old age pensioners went into hospital for short periods. Special arrangements have been made for two old people in High Duddon to have a meal delivered from a local Guest House."

Interesting mention is also made in this report of the work at Cockermouth and Whitehaven, and with regard to Ennerdale the report goes on:—

"ENNERDALE: This service has increased again. The Schools Meals Kitchen provided a special dinner on 19th December, and 'Marchon' kindly produced the meals on 24th and 27th, and double rounds were done on these days. Turkey, ham, sausage and Christmas pudding were served, plus all the etceteras, and 'Marchon' provided each old age pensioner with ½ lb. box of chocolates. W.V.S. members and Mr. de Gara provided specially covered boxes containing butter, sugar, tea, biscuits and crackers for each recipient and the parcels were delivered on Christmas Eve."

The latter quotation with regard to Ennerdale draws attention to the great effort which is made at Christmas time to do something really special for the old people in all of the areas. Normally gifts from individuals or organisations provide extra luxuries at this season, such as bottles of wine, boxes of biscuits, etc.

The point mentioned above with regard to the source of the meals which the W.V.S. deliver is, I think, an important one. The provision of as many as possible of these meals from old people's homes ensures that the studied and balanced diet prepared for the elderly is being uniformly distributed. This by no means detracts from the helpful, and in many cases, very generous service given by school and works canteens in the past, but tends to relieve them of a task to which their cooking services are not specially geared. In addition there is a certain saving through providing the meals from the department's own establishments. Part of the increase in the number of meals being provided is associated with the growing practice of providing a meal more than once a week for the recipients in any area. This emerges very clearly from the above

W.V.S. report and underlines the valuable effect it has in impinging on the loneliness and isolation problem. The growth in due course of day centres and luncheon clubs will begin to replace a certain amount of the meals on wheels service. It will nevertheless continue, I am sure, to expand, if at a slightly less rapid pace than in recent years. The question whether the service will indeed outrun the resources of voluntary workers is still an open one.

Residential Accommodation for Disabled and Handicaped persons

In exercising their duty to provide residential accommodation for persons who, by reason of age, infirmity, or any other circumstances, are in need of care and attention not otherwise available to them, local authorities are required by the Act to have regard to the need for providing accommodation of different descriptions suited to different persons. As far as the aged are concerned, this requirement can normally be met by the provision of single, double or multi-bedded rooms and the use of larger homes for persons needing more care, or those whose habits and outlook make it difficult for them to fit easily into the smaller homes. This latter group is, however, a small one and is not to be expected to maintain its numbers in the future as in the past. Indeed by the time the older homes are replaced by modern I am confident that all of these more difficult individuals will be reasonably well integrated into the newer accommodation. The full services of the department in the form of welfare officer and mental welfare officer attention are focused on this problem, and I am grateful for considerable help during the year from my psychiatric colleagues in this connection.

The provision in the financial year 1965/66 of a home for 20 younger handicapped persons at Maryport will make a very important contribution to this section of the department's responsibility, as well as the provision in the current financial year for a home of 40 places in Whitehaven for the more infirm elderly.

Certain voluntary bodies have facilities to provide on a national scale, residential accommodation for different classes of person, e.g., spastics and other severely handicapped persons. Where appropriate and at the request of the person concerned. the

Health and Welfare Sub-Committee usually agrees to the admission into the homes specialising in a particular form of care, and at the 31st December, 1963, 11 men and two women were accommodated at the following voluntary homes.

Home	Men	Women
Maghull Epileptic Colony, Liverpool	4	2
Church of Scotland Queensbury Lodge Eventide Home	1	
British Legion, Lister House, Sharow, Ripon	2	
Lake District Cheshire Home, Holehird, Windermere	1	
Enham-Alamein Village Centre, Enham-Alamein ...	2	
Ernest Ayliffe Home for the Aged and Infirm Deaf and Dumb, Rawdon, Leeds	1	

Temporary Accommodation

Under the provision of the National Assistance Act, 1948, county and county borough councils are required to provide temporary accommodation for persons homeless, in circumstances which could not reasonably have been foreseen or in such other circumstances as the authority may in any particular case determine. There is no statutory duty on the Council to provide accommodation for families rendered homeless as a result of non-payment of rent or in other circumstances clearly attributable to the family's own default, but such cases have been admitted on humanitarian grounds when there was no alternative.

The accommodation at Highfield House, Wigton, for temporary use has been fully occupied for most of the year, but a major difficulty is experienced in obtaining rehousing for families received into this accommodation. The housing authorites are, however, now more generally ready to accept back for rehousing, after effective rehabilitation, families who are rendered homeless on account of non-payment of rent or otherwise, provided the County Council's rent guarantee scheme is applied to such cases.

It is to be expected not only that problem families will always be with us, many of them being incapable of complete rehabilitation, but that this number may increase. Much of the work of rehabilitating the worst problem families has, in the past, been carried out by the employment of two N.S.P.C.C. women visitors. The principal preventative effort continuously in operation, is still

of course, the daily work of the health visitor and where appropriate the child care officer, probatian officer, etc. The Children and Young Persons Act, 1963, now places a duty on the Council to undertake this preventive work. On the passing of this Act discussions took place with the Children's Officer as to how this department could link best with the Children's Department in improving and streamlining the preventive and rehabilitation services for problem families. A scheme has been devised for the in-service training of selected home helps to function in a way which approximates to the work of "family service units" in direct effort with the most difficult families. Some financial provision has been made for this in the financial year 1964/65. This specific provision, linked to the closer attachment of health visitors to family doctors, and an increased complement of child care officers envisaged by the Children's Department, represents the combined initial attack upon this intractable problem.

The future regulation of the use of the temporary accommodation at Highfield House is under active consideration at the moment. This will in the main be used for the temporary housing of those families requiring the most intensive help in rehabilitation with a view to their returning to the home area for rehousing.

Registration of Private Disabled Persons or Old People's Homes

There are three such homes registered in the county, viz:—

Seaton Villa, Seaton	...	8 persons
Stoneleigh, Gosforth	...	11 persons
Rothersyke House, Egremont	...	14 persons (increased from 10)

Regular inspections are made.

Blind and Partially Sighted Persons

New Registrations

During the year 67 persons were certified to be blind and 27 partially sighted. These fell in the following:—

Age Group	Blind M.	Blind F.	Blind Total	Partially Sighted M.	Partially Sighted F.	Partially Sighted Total
0— 4 ...	—	—	—	—	—	—
5—15 ...	—	1	1	2	—	2
16—20 ...	—	—	—	—	—	—
21—49 ...	—	—	—	2	—	2
50—64 ...	3	7	10	3	1	4
65 and over ...	25	31	56	2	17	19
Totals ...	28	39	67	9	18	27

Registered

The total number of blind and partially sighted persons registered on the 31st December, 1963, are classified as follows:—

Age Group	Blind M.	Blind F.	Blind Total	Partially Sighted M.	Partially Sighted F.	Partially Sighted Total
0— 1 ...	—	—	—	—	—	—
2— 4 ...	—	1	1	—	—	—
5—15 ...	5	4	9	9	3	12
16—20 ...	4	1	5	8	1	9
21—49 ...	33	21	54	9	9	18
50—64 ...	37	41	78	17	14	31
65 and over ...	132	233	365	21	52	73
Totals ...	211	301	512	64	79	143

The newly registered blind or partially sighted person is immediately brought within the Home Teaching service. Persons within the 16/65 age group are referred to the Disablement Resettlement Section of the Ministry of Labour with whom we have close liaison. The Ministry of Labour have now appointed blind placement officers and there is close contact and liaison on all matters of employment whether in open industry or sheltered employment.

Handicraft classes under the supervision of our Home Teachers continue to be held weekly at Penrith, Aspatria, Workington, Whitehaven, Egremont and Millom, the sale of articles made being arranged by the manager of the Workshops for the Blind and the Home Teachers.

Social gatherings, outings, etc., are very popular and very much appreciated.

The distribution of wireless sets (free) on behalf of the Royal National Institute and Wireless Fund is now undertaken by the officers of the department.

During the year meetings were held for the parents of blind children. These play a most useful part in bringing together parents, home teachers, blind placement officers, etc. The sharing of knowledge and experience is of value to all those attending.

The Barrow, Furness and South Cumberland Society for the Blind continue to act as agents for the administration of welfare services for the blind in Millom.

I am indebted to Miss Fraser, home teacher for the blind, for the following very illuminating commentary on the work which she and her colleagues undertake:—

"A home teacher for the blind is particularly concerned with the welfare of blind persons and visits those of all ages—from infancy to old age—in their own homes.

Since the service covers such a wide age group, occasionally the home teacher is concerned with the young blind child, advising and encouraging parents in the best way to help their child and telling them of the educational opportunities available.

It may be that there is a young blind person who loses his sight after receiving his education and training for employment in a sighted world. In such a case the home teacher helps the blind person to adjust to his disability, encourages him to consider rehabilitation at one of the Training Centres in Torquay where he can learn to bridge the gap between the old life and the new, and can eventually be considered for employment in a job suitable to his capabilities.

The majority of people visited by the home teacher are those who lose their sight in later life. It is the home teacher's job to

help them to be as mobile and independent as possible, give them hints on how to safeguard themselves, contact the home help and meals on wheels services when required, advise them of the various pieces of apparatus available which they may find useful.

This apparatus includes white sticks, self-threading needles, milk saver, tape measure, a signature guide (to enable the blind person to sign his own pension book), a venetian writing frame (an aid to writing one's own letters). There are also games specially adapted for the use of the blind—dominoes, draughts, chess, and playing cards to mention a few.

The home teacher is also keen to encourage the blind to take an interest in handicraft work or to learn to read Braille or Moon Type. Wireless sets, Talking Book Machines, Guide Dogs are available according to the needs of the blind. There are also holiday homes run by the R.N.I.B. for persons wishing to go on holiday perhaps accompanied by a sighted friend.

In Workington a social club is held every Tuesday afternoon in the County Council Social Centre. It is well attended, even in the worst weather. The members enjoy meeting for a chat, occasionally someone comes to entertain, or the members themselves provide solo items or take part in the club percussion band.

Club outings are very popular in the summer months. In June we had a tour in the Lake District and called at the Wheatsheaf Inn, Lorton, for tea. This outing was so popular that it was repeated in September. There was also an afternoon outing to St. John's in the Vale and Thirlmere with a visit to Keswick for tea.

A handicraft class is also held in the Social Centre, every Thursday. About ten people come to the class, some of them spend all day working—they make seagrass bags, seagrass stools, tea trays, cocktail trays and teapot stands. The members are so interested that often work is taken home on a Thursday and returned, completed, at the social club on a Tuesday afternoon. So far I have been fortunate in having sufficient orders to keep everyone so busy.

One Thursday in September the members took a day off work for an afternoon train excursion to Keswick with high tea at the Millfield Hotel. This proved to be another enjoyable outing.

All the blind people of Workington and district were invited to the annual party in May, given by the Rotary Club. There was also the annual day outing, paid for by the voluntary organisation in Carlisle, which this year visited Windermere.

The highlight of the year was the Christmas Party in the Cumbria, Workington, on 6th January. Many of the blind people and their guides came to the party in taxis and the majority were taken home by taxi. There was dancing and a concert party to entertain. It was, indeed, a most happy and enjoyable evening and was a topic of conversation for many weeks.

This party was made possible by the Workington Fund for the Blind started by Mrs. Nellie Bell who died suddenly on 28th January.

This year the blind people in the area were keen to raise money for the fund. Their effort took the form of a Bring and Buy Sale on 1st October, when £88 was realised for the Christmas Party Fund."

Workshops for the Blind

The administration of the Workshops at Petteril Bank were taken over by the County and City Councils on 1st December, 1962, and during the year a lot of work has been put in on the reorganisation and industrialisation of the Workshops. I have executive responsibility to the Joint Committee.

Major Holt was appointed Manager and took up his duties on 1st May, 1963.

Following an intensive study of the future of the Workshops and its activities and products, the bedding department with a furniture section is to be mechanised and new machinery for this purpose is being obtained. This is supported by a 75% grant from the Ministry of Labour. Further proposals include the transfer of the Brush department into the main Workshop building, the closing

of the Knitwear section and the provision of storage accommodation. Sales have increased and are expected to continue to do so. The workers have responded and share in the increased activity and productivity of the Workshops.

I quote from Major Holt's report on his work:—

"As the new manager of the workshops, formerly not connected in any way with the employment of blind and disabled persons, I attended a course on employment of blind persons and with an entirely new look at the problems of sheltered workshops was impressed with the new methods and techniques adopted by some of the workshops visited. In many cases mechanised methods of production had been adopted to replace the old hand methods. New products not previously made by the blind had been introduced successfully. My impressions were that generally the blind employee in sheltered workshops was in favour of the adoption of new methods and products. They felt that their career prospects were enhanced if new methods and mechanisation was adopted. The happiest atmosphere was found where the accent was placed on WORK, under-employment having a detrimental effect on morale and accentuating the welfare problems. One of the biggest problems facing workshops is the sale of articles in highly competitive markets. Where an article can be made using machinery and the blind employee can be taught to use the machinery, the article could be produced with a better finish and is more saleable. In order to survive in competitive markets it is necessary to adopt new methods and mechanisation wherever possible and reduce the number of departments and trades.

The factory is a modern single storeyed building in pleasant and extensive grounds on the outskirts of Carlisle at Harraby and is adjoined by a hostel for employees.

There are 19 blind and disabled employees in the Petteril Bank Workshops who are the direct responsibility of the County Council. A total of 33 blind and disabled persons are employed.

The present occupations include upholstery, mattress making, cushions, knitwear, firewood, basketry and brush making.

On the recommendations of the Working Party Report on Blind Workshops, a complete reorganisation of the workshops has commenced and in particular mechanisation of the bedding department is in its final stages with the assistance of grants for new machinery from the Ministry of Labour.

Research into the possibilities of introduction of new products is in progress to provide more profitable occupations for employees.

Visitors are welcome and a showroom has been opened for the public to view products made by the blind and disabled."

Deaf and Hard of Hearing

The agency arrangements have been continued with the Carlisle Diocesan Association for the Deaf for the provision of welfare services of the deaf.

The provision of social centres where the deaf can organise their own social communities has always been an important part of the work of the Association. These facilities are provided in the Institutes at Barrow (for the Millom area) and Carlisle (for North Cumberland) and in the Committee's own premises at Workington.

A casual visitor to these centres might on many evenings see the members simply playing games, watching television, chatting or having supper. The method of communication used is an almost entirely visual one—a combination of finger spelling, signs and speech—with lip reading—and conversation comes as easily to them by this means as it does through speech to hearing people in an ordinary social setting. The pattern of communication may well change substantially, however, in the future since today hearing loss is being detected at a very early stage and many more individuals with this handicap are being enabled to make the most of what residual hearing they possess and to learn speech.

One of the greatest needs of deaf people is the provision of special church services in which they can fully take part. The Association has continued to conduct such services in all centres with the help of chaplains appointed by the Lord Bishop of Carlisle.

The refurnishing of the Chapel at the Carlisle Institute was completed and the dedication of the new ornaments and furnishings by the Lord Bishop of the Diocese took place on 22nd May, 1963.

County Councillor Miss J. E. MacInnes was again re-elected Chairman of the Association.

The number of deaf people in the County of Cumberland analysed for return to the Ministry of Health on 31st December, 1963, were as follows:—

	Ages 16—64	Aged 65 and over
Male		
Deaf with speech ...	10	2
Deaf without speech ...	34	8
Female		
Deaf with speech ...	7	—
Deaf without speech ...	27	3
	78	13

Total 91 persons

Handicapped and Disabled Persons

The Workington Centre is now occupied at some time during each day of the week by the handicapped and disabled persons, the blind and partially sighted classes and the Carlisle Diocesan Association for the Deaf. The premises are also used one afternoon by the mental health section in providing social activities for mental aftercare patients.

All persons registered as handicapped in the Workington area are encouraged to attend the Centre and transport is arranged for persons unable to travel by public transport.

The provision of this Centre has proved to be well worth while.

The Millom Centre, operating for a smaller group at a mixed Social/Craft session on Thursday afternoons, has continued and is now showing an upward trend in attendances.

In July, 1961, the Ministry of Health issued a circular relating to the issue of special badges. The object is to ease the difficulties of severely disabled drivers in finding suitable parking places and the display of such badges on disabled drivers' vehicles will enable them to be readily identified, both by the police and by other road users.

The county register now totals 278 persons classified as follows:—

	Persons aged 16—64		Persons aged 65 and over		Total	
	M.	F.	M.	F.	M.	F.
Amputation	14	3	3	2	17	5
deformities	9	11	5	3	14	14
Arthritis and rheumatism ...	29	18	1	1	31	19
Congenital malformations and Diseases of the digestive and genito-urinary systems; of the heart; of circulatory system; of respiratory system (other than turberculosis) and of the skin	18	5	12	1	30	6
Injuries of the head, face, neck, thorax, abdomen, pelvis or trunk. Injuries or diseases (other than tuberculosis) of the upper and lower limbs and of the spine	31	3	4	—	35	3
Organic nervous diseases — epilepsy, disseminated sclerosis, poliomyelitis, hemiplegia, sciatica, etc.	37	23	4	—	42	23
Neuroses, psychoses and other nervous and mental disorders not included above	8	6	—	—	8	6
Tuberculosis (respiratory) ...	3	2	—	—	3	2
Tuberculosis (non-respiratory)	7	2	—	—	7	2
Diseases and injuries not specified above	7	4	—	—	7	4
					194	84

Total 278

The development of the domiciliary care and support of the handicapped in the community is very much before me at present and I am glad that in the very near future there will be three full-time welfare officers operating in the county to whom this group

will fall as a major responsibility. A serious gap in the services for such individuals in this area is the absence of industrial rehablitation provision by the Ministry of Labour. The provison of such facilities with hostel accommodation at such centres as Felling in County Durham makes no significant contribution to Cumberland's needs in this matter. I know that the specialists in hospital under whose medical or surgical care many of these handicapped people come, share my concern at the urgency of this position. A few individuals suffering from handicaps other than blindness have been incorporated into the work of the Workshops for the Blind, but this institution cannot be looked to in the immediate future to making substantial contribution to the rehabilitation or sheltered employment of the physically handicapped.

Voluntary Organisations

Mr. R. Mulelly, the Secretary of the Cumberland Council of Social Service, has made the following comment on the work of the voluntary organisations during, 1963:—

"The past year has witnessed a further strengthening of the excellent relationships that exist between the Health and Welfare Authority and the voluntary organisations. The latter have responded well to the challenge of new opportunities, presented by a progressive Authority, to make their own special contribution to the care which the community provides for those in need. They have been assisted in this by the establishment of the Area Welfare Committee in whose work the Council of Social Service has been happy to play its full part.

Of the Council's own work, generously assisted by the Authority, perhaps it will be enough to mention two projects that have about them the qualities of pioneer efforts.

Regular pre-retirement courses for older workers have been established in Workington and the Council is seeking to extend them to other areas. Without exception, the men taking part have testified enthusiastically to the value of the courses.

Another break-through has been achieved by the provision of training courses, of a non-specialist nature, for voluntary helpers.

Already there are clear indications that those who give voluntary service welcome simple instruction and background information as a means of increasing both their skills and the satisfaction derived from employing them. In this, as in other spheres, the Council is indebted to the County Medical Officer and his staff for their interest and a great deal of practical assistance."

GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

INFECTIOUS DISEASES

The infectious diseases notified during the year and shown on the following table once again show a pattern which has become familiar in the absence of any substantial numbers of serious infections. Notifications of measles continue high with an increase in whooping cough notifications this year, many of them occurring in school children.

The numbers notified suffering from dysentery are substantially reduced in comparison with the previous two years although it is never possible to be quite sure how comprehensive is the notification of gastro-intestinal infections. There is no doubt that dysentery and food poisoning cases continue to require the recurrent attentions of the district medical officers of health and often serious outbreaks can still only be prevented by careful attention to isolating cases and groups of cases and the tracing of the source of the infection to a kitchen worker or other food handler. In this connection it is important to note the reappearance of typhoid fever in the table. This was an isolated case associated with the small outbreak in this country originating in Switzerland. The marked increase in recent years in continental holiday travel from this country has brought with it just this sort of risk with all the attendant problems as to advising on the need for immunisation against typhoid when the risks are ill defined in many cases.

Associated also with food borne infections is the problem of brucellosis and the difficulty of ensuring that all of the milk consumed in a rural area is safe from this point of view. The disease not being notifiable, and also often being difficult of diagnosis, makes it very difficult to assess the morbidity which arises from this infection. There is no doubt that in many cases it can be responsible for insidious ill-health over quite a long period, and while measures are being taken by the Ministry of Agriculture, Fisheries and Food to promote the maximum vaccination of calves against brucellosis, it seems clear that only 100% heat treatment of milk is likely to solve the problem completely. This raises problems of hardship for small isolated rural communities, and much thought is being given to the problems of this infection in many quarters.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES, 1963

	Scarlet Fever.	Whooping Cough.	Ac. Poliomyelitis Paralytic.	Measles.	Dysentery.	Meningococcal Infection.	Acute Pneumonia.	Acute Encephalitis Infective.	Post Infectious.	Enteric or Typhoid Fever.	Paratyphoid Fever.	Erysipelas.	Food Poisoning.	Tuberculosis Respiratory.	Meninges and C.N.S.	Other.	Puerperal Pyrexia.
URBAN DISTRICTS—																	
Cockermouth	1	—	—	188	10	—	—	—	—	—	—	—	1	3	—	1	—
Keswick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—
Maryport	7	12	—	23	—	—	1	—	—	—	—	1	4	10	—	1	—
Penrith	3	7	—	213	4	—	3	—	—	1	—	—	—	1	—	—	1
Whitehaven	3	17	—	177	—	—	3	—	—	—	—	—	4	8	—	1	—
Workington	1	42	1	33	3	5	1	—	—	—	—	1	—	13	1	1	10
RURAL DISTRICTS—																	
Alston	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	—	1	—	271	—	—	1	—	—	—	—	—	6	6	—	1	1
Cockermouth	2	10	—	95	21	—	2	—	—	—	—	1	3	9	—	1	—
Ennerdale	1	17	—	290	—	—	3	—	—	—	—	—	—	13	—	3	—
Millom	—	1	—	279	—	—	3	—	—	—	—	1	5	5	—	1	—
Penrith	—	6	—	230	11	—	4	—	—	—	—	—	8	3	—	—	—
Wigton	5	6	—	36	1	—	1	—	—	—	—	—	—	5	—	1	—
TOTAL FOR YEAR ...	23	119	1	1836	50	5	22	—	—	1	—	4	31	76	1	12	12
1962	35	39	2	2485	149	6	40	—	1	—	—	4	40	94	1	12	33
1961	57	72	4	2204	149	—	85	—	—	—	—	10	15	80	—	15	21
1960	114	392	—	1999	35	2	83	—	1	—	—	6	95	126	1	16	9
1959	254	153	—	3363	21	1	90	1	—	2	1	13	56	127	2	16	47

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights and Measures for the following report:—

FOOD AND DRUGS ACT, 1955

Summary of work done under the above Act during the year ended 31st December, 1963

	Total Samples Obtained		Genuine		Unsatisfactory	
	Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
Submitted to Public Analyst ...	35	246	17	231	18	15
Tested by Sampling Officers ...	443	—	424	—	19	—
	478	246	441	231	37	15
	724		672		52	

During the year under review, 724 samples were obtained of which 478 were samples of milk and the remainder consisted of various foods and drugs.

Due to the cost involved of having samples of food analysed, the number of samples submitted to the Public Analyst is limited, but every endeavour is made to cover as wide a range of foodstuffs as possible. These foodstuffs also include a number of samples of fruit and vegetables submitted under a scheme started some time ago for the examination of such articles for pesticide residues resulting from the use of sprays and dressings of insecticides. It was considered that it would be an advantage if samples could be obtained chiefly of local produce as the Analyst receives samples from a number of local authorities and so covers a very large area of the country. On the completion of a two year investigation covering this subject, the Analyst reported that there were grounds for concluding either that spraying of fruit and vegetables is less widespread than is commonly supposed, or that adequate

precautions are being taken by commercial growers to prevent dangerous residual contamination occurring at the time when the crops are marketed. The samples submitted from this authority included lettuce, cauliflowers, beetroot, spring onions, cabbage, strawberries and blackcurrants. All were satisfactory with the exception of a sample of spring onions which gave a doubtful reaction when tested, but two further samples were taken which were satisfactory.

Although the results of sampling under this scheme have been satisfactory so far, it is considered desirable for many more samples of fruit and vegetables to be taken and examined under the Food and Drugs Act.

With regard to drugs, it has been alleged that the pattern of drug sampling under the Act has not kept pace with the changes in prescribing and that the older remedies which are still sampled are not, in fact, in common use. A list of modern proprietary drugs suitable for testing were received from the Analyst and a number of these drugs have been submitted for analysis, the results being satisfactory.

All the samples of foodstuffs and drugs (246), together with 35 of the milk samples, were submitted for analysis. The remainder of the milk samples were tested by Gerber apparatus in the Inspectors' offices. The average quality of the latter samples (443), including 19 slightly below standard, was fat 3.68% and non-fatty solids 8.63%. These figures compare favourably with the presumptive standard which is 3.0% fat and 8.5% solids-not-fat. The averages referred to do not include Channel Islands milk which requires a higher standard for fat, 4%. All the samples of this type of milk were of satisfactory quality.

The percentage found to be unsatisfactory of the total number of samples taken was 7.2. Of the milk samples, 7.7% were below standard and other foodstuffs contained 6.1% of unsatisfactory quality.

The unsatisfactory samples were dealt with as follows.

Milk

Two samples of milk contained extraneous water and the producer was prosecuted. The magistrates were of the opinion that the defendant had not deliberately added water to the milk, but had been negligent in handling the milk, and they dismissed the case on payment of £10/10/0 costs.

One sample was certified to contain a small percentage of extraneous water. In this case the milk was collected from the farm on the bulk collection system and it appeared that the small percentage of water in the original sample was due to the farmer passing water through the pipe line to the collecting tank in order to expel the last drop of milk. He was cautioned that he must not allow any water to pass into the storage tank and the amount of milk that normal suction failed to extract would have to be regarded as expendable. Two samples taken at the farm in relation to the original sample were slightly below standard in non-fatty solids, but were of genuine quality. However, it was found that the producer had already taken steps to improve the quality of the milk.

Two samples of milk were deficient in fat. Further samples were taken later from the same source of supply and found to be of satisfactory quality.

The majority of the milk samples certified by the Public Analyst to be unsatisfactory (11), although of genuine quality, were sub-standard. The producers were notified of the results to enable them to take steps to improve the quality of the milk. The decline in quality occurred in the early spring when it frequently happens that cows, being put out to grass after winter feeding, produce milk of a lower quality. In the instances referred to, further samples were taken later and it was found that the quality in each case had improved to reach the required standard.

Of the 443 samples of milk tested by the Sampling Officers and not submitted to the Public Analyst, 19 were slightly below standard. In such cases it is the practice to take further samples at a later date to see if the quality has improved. If the results are

still unsatisfactory, samples are submitted to the Analyst to confirm the findings of the Sampling Officer and the matter is then taken up with the producer concerned. This is the normal procedure adopted for samples only slightly below standard, but when the initial tests carried out by the Sampling Officers indicate more than slight variations from the presumptive standard, or doubtful results are obtained, formal samples are immediately forwarded to the Public Analyst.

Unsatisfactory Foodstuffs other than Milk

The number of unsatisfactory samples of foodstuffs, other than milk, certified by the Public Analyst to be unsatisfactory, was 15. A number of these were cases of labelling infringements concerning potted meat, cress, children's cough syrup, cough linctus and beef steak with gravy. The attention of the manufacturers was drawn to these infringements to enable them to amend the labels so as to conform with the requirements of the Regulations.

A sample of rice was found to contain a small amount of foreign matter consisting mainly of wheat, maize and other vegetable seeds. The packers stated that each bag of rice received by them is sampled at the top and bottom of the bag and only when the samples are passed by their laboratory staff is the rice released for pre-packing. They could only assume that the foreign matter must have been present at the bottom of one bag and escaped detection during sampling. No further action was taken as it was appreciated that all reasonable precautions appear to be taken during the packaging of this article and the foreign matter referred to would not have constituted a health hazard.

A loaf of bread, submitted for analysis as a result of a complaint by the purchaser, was certified to be contaminated with a mixture of oil, iron and rust. The contamination was probably due to lubricant leaking from the dough mixing machine and the baker was cautioned. He overhauled the machine but was unable to find any leakage.

Two samples of different types of canned meat were found to be deficient in meat content. Although there is no official standard

for such articles, the Food Standards Committee have recommended minimum quantities and the Analyst based his findings on these recommendations. The attention of the manufacturers was drawn to the variations. In one instance it was found that the sample was from old stock and the manufacturer had ceased production of that particular item.

A beverage having the appearance and flavour of lager beer was found to have an exceptionally low (non excisable) alcohol content, but the label gave the impression that it was a normal lager. However, no action was taken as it was found that the same type of beverage was the subject of a prosecution by another authority which had resulted in the manufacturers being fined. Steps would be taken by the manufacturers to amend the label so as not to mislead the purchaser.

A tin of corned beef, delivered to a school canteen, was sent to the Public Analyst when it appeared that the contents were contaminated. The Analyst stated that the meat was discoloured with iron derived from attack on the inside of the can. The metallic contamination had not penetrated into the bulk of the material, but the surface was badly contaminated. The school canteen was supplied with another tin of corned beef of good quality in place of the faulty one, and the attention of the importers was drawn to the fact that meat marketed by them must be of satisfactory quality.

In a few instances foodstuffs were so unsatisfactory as to warrant legal proceedings being taken. Two samples of corned beef were taken from a consignment supplied to a school canteen. One tin of corned beef contained a mixture of foreign bodies, pieces of fabric resembling a finger bandage, two large black bristles, some bone, a piece of skin and numerous black particles resembling pieces of liver. The other sample was contaminated with iron. A prosecution was taken against the importers, the corned beef having been produced by their subsidiary company in Australia, and they were fined £100.

A carton of orange drink had been purchased from a vending machine by a member of the public for a child who was unable to drink the liquid on account of its unpleasant taste. This was due

to the orange drink being contaminated with mould growth. The manufacturer was prosecuted and fined £20.

A firm of bakers was prosecuted and fined £50 plus £3/10/0 costs in respect of a loaf of bread containing pieces of glass.

Complaints Regarding Unsatisfactory Foodstuffs

During the past few years, complaints from members of the public concerning unsatisfactory foodstuffs have become more prevalent, probably due to the wide publicity given to consumer protection rather than indicating that less care is being taken in the manufacture of foodstuffs. All the complaints were investigated, some being justified and some not.

Complaints regarding contaminated bread, orange drink and corned beef, foreign bodies in corned beef, and bread containing pieces of glass, have already been referred to under the section dealing with the analysis of unsatisfactory samples. Other complaints were dealt with as follows.

A purchaser of a loaf of bread found that it contained a cigarette end. The manager of the bakery firm concerned was prosecuted for the offence and fined £40.

A bar of milk chocolate was alleged by the purchaser to contain a particle of glass, but he was unable to prove the existence of any foreign body. The remainder of the bar of chocolate was sent to the Analyst, but there was no trace of anything harmful in the chocolate.

A complaint was received regarding black puddings, the skins being spotted with white mould. The contents of the skins were quite edible, but the butcher was cautioned that he must not use skins affected in any manner as to make them unfit for human consumption. The remainder of the black puddings in the shop were withdrawn from sale.

Some tinned peaches contained a dead insect for which the packers were cautioned. They compensated the housewife by sending her a supply of tinned fruit and she was quite satisfied with the result of the enquiry.

An allegation that milk contained bovine blood was investigated and samples were submitted to the Cumberland Path. Laboratory. These samples revealed the presence of red blood cells, but no obvious pus cells. The culture report proved negative for the organisms of bovine mastitis. The sampling officer sought the advice of the Ministry of Agriculture (Animal Health Division) and their representative visited the farm. From the informaton given as a result of this visit, it was felt that no further action should be taken, particularly in view of the splendid record of the farmer concerned.

Two complaints were investigated concerning slivers of glass found in bottles of school milk. As will be appreciated this could have proved very dangerous to children drinking the milk. In both cases it was impossible to attach the blame to any one person, or persons. Investigations were made at the bottling plants of the dairies concerned and it was proved that the particular bottles could not have been broken during the bottling process and the damage must have been caused during the handling of the crates. The people concerned with the handling were the wholesale dairies, retailers and School Meals Service. The dairies and retailers were asked to handle the crates with more care and similar instructions were issued to the drivers of vans in the School Meals Service in cases where the vans are also used for the delivery of school milk.

A housewife complained to her grocer about the contents of a tin of grapefruit she had purchased, as the fruit contained small yellow particles and looked anything but appetising. The retailer contacted the department and the grapefruit, together with an unopened can, were submitted for analysis. The Analyst reported that the yellow particles consisted of naringin which is a natural bitter principle of grapefruit and it frequently forms crystals under conditions of sterilisation in the can and is quite harmless.

Another housewife complained of the quality of fresh cream she frequently purchased. A sample was taken from the same source of supply and showed the cream to be of satisfactory quality and the complainant was notified of the result.

Milk (Special Designation) Regulations

These Regulations require that all milk sold by retail is in bottles or cartons which have to be labelled in a specified manner. In some isolated areas these Regulations are exempt to farmers who do not hold producers' T.T. licences and have only a few customers, provided there is no alternative supply of bottled milk available. However, in such cases the farmer must also obtain a Consent from the Ministry to be exempt from the Regulations. The amount of milk supplied under such conditions is very small, most of the milk throughout the County being either bottled, or in cartons, correctly designated. There have been a few isolated cases where the containers have not complied with the Regulations with regard to labelling, but steps were taken by the retailers for the correct designations to be used and no further action has been necessary.

WATER AND SEWERAGE

Water Schemes

The transfer of water undertakings of District Councils to the Water Boards continued during the year with the formation on 1st April, 1963, of the Eden Water Board, which took over the undertakings of the Penrith Rural, Penrith Urban and Alston Rural Councils.

As in 1962, only two new Schemes were submitted for the County Council's observations under the Rural Water Supplies and Sewerage Acts. One Scheme was for the augmentation and improvement of supplies in the Border area of Gilsland and Nether Denton, which is supplied by the Newcastle and Gateshead Water Company. The second, was a small extension to afford new supplies in the Windscales area.

The Carlisle Corporation submitted further details, plans and specifications for their large Scheme, estimated to cost £699,500 to augment supplies in the Northern and Eastern parts of the Border Rural District, and this Scheme was approved as sound and fully adequate to meet the needs of the District.

Notification of Ministry grant for the following five Schemes was received during the year and similar contributions were made by the County Council in all but Item 3 below.

Grants

1.	Windscales to Crossbarrow Water Supply.	£420.
2.	Wigton Water Scheme. Stage IV, Part 1.	£1,288 per half year for 30 years.
3.	Water Main Ext. Border Limits.	35% of Annual Guarantee payments to Newcastle and Gateshead Water Co. (County Council Grant 32.5% of Annual Guarantee payments).
4.	Caldbeck Parish Water Supply.	£864 per half year for 30 years.
5.	Ireby and District Water Supply.	£328 per half year for 30 years.

Sewerage

Three new Sewerage schemes and further details of the St. Bees Scheme were submitted during the year and details are set out in the Schedule.

Notification of Ministry Grants was received in respect of the following schemes and similar contributions were made by the County Council:—

1. Durdar Sewerage Scheme £1,903
2. Arlecdon and Winder Ghyll Sewerage Schemes £1,395

Water Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants Ministry	Grants County	Remarks
Border R.D.C.	Water Main Ext. Gilsland and Nether Denton Area.	To maintain and augment supplies in the Gilsland and Nether Denton area.	£16.000	35% of Annual Guar. payments to Newcastle and Gateshead Water Co.	32.5%	Scheme approved as sound and adequate.
W.C. Water Board	Windscales to Crossbarrow	To afford 8 new supplies and 2 improved supplies.	£2,000	£420	£420	Completed.
Carlisle Corporation	Major Capital Expenditure Programme.	Scheme to augment supplies in Northern and Eastern parts of the Border Rural District.	£699,500 (Est.)	—	—	Approved as sound and fully adequate to meet the needs of the district.

Sewerage Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants Ministry	Grants County	Remarks
Wigton R.D.C.	Oughterby Sewage and Sewerage Disposal	Sewers and treatment works.	£9,000 (Est.)	—	—	Decision on Scheme deferred pending further enquiries re the treatment of farm waste.
Keswick U.D.C.	Improvement to Sewage Disposal Works.	—	£80,000	—	—	Approved as sound and adequate. Work commenced September, 1963.
Ennerdale R.D.C.	Arlecdon and Winder Ghyll Sewerage Scheme	Scheme to take sewage from the abandoned works at Skelsceugh Road to existing works at Winder Ghyll.	£4,612	£1,395	£,1395	Completed.
Ennerdale.	St. Bees Sewage Disposal.	Scheme to deal with sewage disposal from St. Bees.	---	---	—	Approved as sound and adequate.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1963

(N.B.—Corresponding figures for 1962 are shown in brackets)

		Alston R.D.C.	Border R.D.C.	Cocker-mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Total for R.D.C.'s in County	White-haven Boro"	Working-ton Boro'	Cocker-mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
	Population — 1951	2,327	29,845	20,455	29,676	13,428	11,723	23,746	131,200	24,620	28,891	5,235	4,868	12,234	10,492
	(Census) — 1961	2,105	29,644	20,966	30,859	15,094	11,638	21,866	132,172	27,566	29,552	5,827	4,765	12,393	10,927
A 1	Total number of occupied dwelling houses in the district	821 (852)	8,869 (8,681)	6,712 (6,553)	9,727 (9,525)	4,510 (4,462)	3,670 (3,770)	7,300 (7,206)	41,609 (41,049)	7,883 (7,681)	9,025 (8,942)	2,027 (2,080)	1,670 (1,629)	3,986 (3,990)	3,539 (3,479)
2	Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings:	3 (3)	— (—)	13 (18)	174 (112)	— (—)	39 (23)	14 (11)	243 (167)	38 (94)	19 (37)	82 (51)	1 (7)	58 (77)	22 (24)
3	Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost ...	15 (31)	204 (236)	72 (87)	511 (726)	212 (64)	88 (91)	284 (270)	1,386 (1,505)	150 (200)	20 (10)	154 (185)	3 (7)	135 (136)	67 (80)
4	Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	59 (70)	580 (640)	N.A. (N.A.)	1,217 (1,279)	184 (297)	465 (470)	1,232 (1,259)	3,737 (4,015)	N.K. (N.K.)	80 (70)	20 (28)	85 (95)	88 (89)	55 (60)
5	Number of houses found to be overcrowded	6 (6)	21 (17)	2 (9)	5 (6)	11 (8)	30 (40)	5 (5)	80 (91)	— (—)	N.K. (—)	— (—)	— (—)	— (—)	4 (2)
B	WAITING LISTS Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above	17 (21)	*1 182 (236)	382 (448)	537 (579)	161 (246)	*2 50 (—)	404 (426)	1,733 (1,956)	916 (952)	800 (886)	*3 172 (322)	171 (140)	289 (351)	197 (202)
C	NEW DWELLINGS COMPLETED DURING THE YEAR														
1	By or for the Council—														
	For aged persons	— (4)	5 (4)	9 (3)	18 (10)	— (8)	8 (6)	30 (10)	70 (45)	— (—)	16 (—)	— (—)	— (—)	— (—)	— (—)
	For aged persons grouped with welfare facilities	— (—)	24 (—)	15 (—)	— (—)	— (—)	— (—)	— (20)	39 (20)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	3 (—)	3 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings	— (10)	7 (—)	73 (8)	192 (152)	30 (6)	— (8)	44 (18)	346 (202)	64 (107)	70 (45)	35 (36)	— (14)	10 (5)	4 (2)
2	Private building	1 (1)	200 (192)	83 (86)	69 (111)	33 (52)	28 (29)	21 (24)	435 (495)	69 (24)	72 (69)	50 (9)	— (—)	5 (2)	56 (16)
	Total of 1 and 2 ...	1 (15)	236 (196)	180 (97)	279 (273)	63 (66)	36 (43)	98 (72)	893 (762)	133 (131)	158 (114)	79 (45)	— (14)	15 (7)	60 (18)
D 1	Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants)	8 (14)	97 (63)	62 (40)	83 (60)	74 (67)	50 (56)	65 (63)	439 (363)	53 (25)	72 (41)	4 (9)	15 (13)	27 (25)	14 (20)
2	Number of houses for which grants were approved	8 (14)	89 (59)	62 (40)	70 (60)	66 (67)	49 (55)	65 (62)	409 (357)	48 (19)	49 (40)	4 (9)	15 (13)	27 (25)	12 (18)
3	Number of houses where improvements were carried out and grants paid	11 (7)	64 (66)	49 (55)	64 (55)	53 (54)	46 (50)	60 (101)	347 (388)	12 (13)	18 (51)	5 (7)	11 (11)	22 (22)	8 (11)
4	Number of houses purchased or taken over by the Council with a view to improvement or conversion	— (—)	9 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	9 (—)	— (—)	— (—)	— (—)	9 (—)	— (—)	1 (1)
5	Number of houses improved by the Council— (i) with grant	— (—)	4 (1)	— (—)	12 (3)	— (—)	— (—)	— (—)	16 (4)	— (—)	1 (—)	— (—)	4 (1)	— (—)	— (—)
	(ii) without grant	— (—)	2 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	2 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	8 (—)
E	HOUSING PROGRAMME FOR ENSUING YEAR—														
1	Dwellings to be built by or for the Council—														
	For aged persons	— (—)	4 (5)	11 (9)	63 (53)	20 (18)	16 (26)	30 (26)	144 (137)	— (—)	— (—)	15 (—)	20 (20)	34 (40)	— (4)
	For aged persons grouped with welfare facilities	12 (12)	20 (25)	— (15)	20 (24)	— (—)	— (—)	— (—)	52 (76)	— (—)	— (—)	21 (20)	— (—)	20 (—)	20 (27)
	For agricultural workers	(—) (—)	(—) (—)	(—) (—)	(—) (—)	(—) (—)	(—) (—)	(—) (—)	— (—)	(—) (—)	(—) (—)	(—) (—)	(—) (—)	(—) (—)	(—) (—)
	General purpose dwellings	— (—)	51 (24)	25 (62)	295 (199)	8 (28)	— (—)	121 (54)	500 (367)	144 (125)	100 (120)	48 (91)	20 (40)	100 (60)	3 (7)
2	Private building	1 (1)	N.K. (N.K.)	50 (90)	50 (100)	20 (40)	25 (30)	27 (14)	173 (275)	60 (30)	100 (60)	50 (45)	4 (2)	40 (50)	40 (50)
	Total of 1 and 2 ...	13 (13)	75 (54)	86 (176)	428 (376)	48 (86)	41 (56)	178 (94)	869 (855)	204 (155)	200 (182)	134 (156)	44 (62)	194 (150)	63 (88)

* 1. As result of review.

* 2. Old People's List only.

* 3. Excluding 191 applications from residents in other areas.

APPENDICES

I. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.

II. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.

III. Mass Radiography.

IV. County Council Clinics.

APPENDIX I

Annual Report on Tuberculosis and other Chest Diseases in West Cumberland in 1963 by Dr. R. Hambridge

In keeping with current trends throughout the country, the past year has seen a further fall in both the death rates and prevalence of tuberculosis in this area. The death rate is now one tenth of the value of 10 years ago: morbidity has not declined with such dramatic speed, but a fall from 280 cases to 70 annually is a welcome reduction. Provided that the general levels of employment, reasonable prosperity and improved housing are maintained, there appears good ground for forecasting the possibility of a death rate of zero in the forseeable future. Already several sanitary areas in West Cumberland, previously notorious black spots of epidemic tuberculosis, have achieved this figure: with continued application of the principles of early diagnosis and adequate treatment, further progress may ensue. The reduction in numbers of cases diagnosed has enabled the Chest Service to accept fuller responsibilities in non-tuberculous chest disorders: and the year has marked a rapid increase in the numbers of common chronic respiratory infection, and the allergic disorders, attending the Chest Clinics. With much more stringent supervision of the several hundred known cases of pneumoconiosis in the Ennerdale and Whitehaven districts, the high incidence of undiagnosed pulmonary tuberculosis and cancer found in previous years at autopsy in such cases has fallen to zero: and the enhanced effectiveness of standard drug treatment, when combined with steroids, in the tuberculosis pneumoconiotics, now gives a measure of control previously quite impossible.

These improvements in health are reflected in the more detailed statement of the Chest Service activities for the year, which follows.

New Cases

The total number of all forms of tuberculosis diagnosed during the year was 71 (92 in 1962; 281 in 1953). Notifications were again highest in Workington, followed by Ennerdale, Maryport, Whitehaven and Millom in that order.

Of the 71 cases, 13 were frankly infectious at diagnosis, and for the first time there were more women (8) than men (5), in the sputum positive category.

The case rate based on the Registrar General's mid-year population estimate was 0.5 per 1000 population (0.64 in 1962; 2.1 per 1000 in 1953).

Tuberculosis Register

The Clinic Tuberculosis Register at the 31st December, 1963 contained the names of 707 notified cases (868 in 1962; 1219 in 1953)

Recovered cases totalled 236, of which 117 were men, 104 women and 15 children.

Of 18 cases removed from the Register because of death, 4 were attributable to tuberculosis, the others dying of non-tuberculous causes. The tuberculosis mortality rate for the year was thus 0.029 per 1000 (0.05 in 1962; 0.29 in 1953).

The proportion of infectious cases has again declined — 18% in 1963, 26% in 1962.

In addition to the cases listed on the active register is a larger number of cases deemed "safe" but whose residual disease appears to call for only occasional review and assessment. These total 1081 respiratory disease, and 114 non-respiratory forms.

Table I.

Year		Age in 10 Year Groups 0-9	10-19	20-29	30-39	40-49	50-59	60-69	70 & over
1953	...	26	44	75	57	27	32	14	6
1963	...	1	7	15	12	13	7	10	6

From the table above it will be seen that the major reduction in morbidity between 1953 and 1963 has occurred in persons younger than 30, where now only one sixth the number of cases occurs: even from 30 to 60 there has been a fourfold reduction.

Summary of Chest Clinic Statistics

Out-patient sessions have continued at the Chest Clinics at Workington, Egremont and Millom. A small number of out-patients has again attended at Homewood for specialised investigations. Workington Chest Clinic remains the centre for records and all chest service clinical administration. At Workington 265 sessions were held, at which 1250 new cases were seen and attendances totalled 3257, showing an increase of some 250 new cases and a similar increase in attendances compared with a year ago. At Egremont, 173 sessions were held, at which 663 new cases were seen, and attendances totalled 2492: showing a slight drop in new cases and total attendances. At Millom, 11 sessions were again held for an increased total of new cases, 93 (53 in 1962), and attendances 206 (171 in 1962).

Contacts of Tuberculosis Cases

Familial contacts of cases on the Register seen at clinics during the year totalled 1222 (1237 in 1962). Of these, new contacts amounted to 756 — a ratio of approximately 10 contacts for each new case diagnosed. Contacts seen previously and remaining under clinical supervision totalled 466. As in previous years the preponderance of children in this group continues: most adult contacts have been referred to the Mass X-Ray Unit, but it is certain that this practice will have to be abandoned in the current year.

Of the children seen at the Chest Clinics, 501 were skin-tested with 1/1000 Old Tuberculin: 20 gave positive reactions. In the 0—4 years age group, of 306, the reactor rate was 0.3%: in the 5—9 years, 5.3% and in the 10—14 years group, 15.9%. In recent years there has been considerable fluctuation in the reactor rates of contacts seen at the clinics — no doubt an expression of the living conditions and infectiousness of individual new cases diagnosed during 1963. As has been already noted, a smaller proportion of new cases was infectious when diagnosed compared with previous years: correspondingly a smaller proportion of young contacts has been found infected when first seen. The figures for 1962 for the three age groups quoted above were:—

0— 4	:	3.1%
5— 9	:	11.3%
10—14	:	19.4%

From amongst the 20 infected children it is certain that future cases of tuberculosis will arise, for this phenomenon is regularly being observed amongst the now adolescent contacts found infected in 1953 when infants. The prevention of tuberculosis lies, as with any infectious disease, in preventing infection, and this can best be achieved by diagnosing cases before they become infectious, i.e. by routine radiography.

B.C.G. Vaccination

Routine prophylactic vaccination with B.C.G. has been offered to all susceptible contacts, some 560 children being vaccinated. This figure includes 86 neonates, born of parents with either a family history or a personal medical history of tuberculosis.

A very much more extensive vaccination programme over the last 9 years has been carried out by the School Medical Officers, and it is now extremely rare to find a young adult in West Cumberland who has not had B.C.G. or a primary infection. Full details of this scheme appear annually in the Report of the Principal School Medical Officer, in which department now a very considerable measure of tuberculosis control, through prevention, is vested.

All nursing and ancillary professional and technical grades of staff in the group are tuberculin tested and offered vaccination. During the year, 9 junior nurses were given B.C.G.

Case Finding Procedures

In addition to the Mass X-Ray Unit's regular programme throughout the year, open sessions for general practitioner referrals have continued at Workington Chest Clinic twice weekly: routine ante-natal chest x-rays have been consistently arranged on all booked confinements at Workington Infirmary and Maryport Cottage Hospital; a smaller number of such examinations has also been made at Whitehaven.

Figures for these several programmes follow:—

Mass X-Ray Unit	:	17012 attendances
Routine ante-natal	:	891 attendances (624 at Workington: 267 at Whitehaven)
X-Ray at Chest Clinics	:	936 attendances.

In its separate section, full details are given of the work of the Mass X-Ray Unit in both East and West Cumberland: and attention is drawn to the impending changes in this sphere of case finding. These will, in all probability, be implemented during 1964, in conformity with the policy of the Regional Hospital Board, and it is to be hoped that alternative arrangements and procedures will be at least as successful in operation and as convenient to the public in arrangements as has been the Mobile Unit over the past decade.

Treatment

At Homewood (Ward E, West Cumberland Hospital, Hensingham) 41 beds were available during the year for the treatment of tuberculous and non-tuberculous chest conditions: the average daily bed occupancy was 28.02 (68.35%) and during the year, discharges and deaths totalled 194 (159 in 1962). There has been no waiting list and all admissions have been effected as soon as arranged. The average duration of stay has fallen to 52.73 days.

For most of the year the proportion of tuberculous to non-tuberculous patients accommodated has been 1 : 1.

Surgical cases have again been transferred to Seaham Hall, where during 1963 only 3 cases required resection for tuberculosis. No cases of bronchiectasis were submitted for surgery, but there has been an increase in the number of intrathoracic neoplasms so treated.

The number of cases of tuberculosis where organisms have been shown to be resistant to the standard forms of drug therapy has again fallen, and throughout 1963 one case only of complete

resistance and 5 cases of partial resistance have received special consideration and treatment. No new cases of known resistant organisms were identified.

Lung Cancer

The total number of cases seen at the Chest Clinics in the year was 34 (21 in 1962; 18 in 1961). The number of deaths attributable to this cause in patients seen at the Clinics in 1963 was 21 (13 in 1962; 13 in 1961).

APPENDIX II

Annual Report on Tuberculosis and other Chest Diseases in East Cumberland by Dr. J. H. Morton

INTRODUCTION

The number of new cases of pulmonary tuberculosis discovered in the East Cumberland Hospital Management Committee area dropped to a new low level of 37 for 1963, the first time this figure has fallen below 50. The active Tuberculosis Register for the whole of the area fell also to a new low level of 539 at the end of the year. For the first time no new case of pulmonary tuberculosis was found in the North Westmorland area. Of the new cases found last year approximately one third had a positive discharge when first examined.

On the other hand the number of new cases of pulmonary neoplasm coming to our notice reached a new high level of 74. In practically all these cases no previous X-ray examination had been carried out, and as a result only one case out of 74 was considered suitable for surgical treatment. The anticipated withdrawal of the locally based deep x-ray therapy facilities is therefore very serious as far as our patients are concerned, and it is discussed later on in this report.

The substantial reduction in the number of cases of tuberculosis with a corresponding diminution in the infective pool in the community has reduced the effectiveness of the mobile mass radiography unit as a diagnostic measure in tuberculosis. When this service was introduced in the 1940's it was primarily designed to find new cases of pulmonary tuberculosis, particularly amongst workers in factories and other establishments. The policy was to x-ray as many workers as possible with minimum interruption in production of the factory. Recent surveys have made it clear that now, in 1964, the mass radiography surveys in factories are unrewarding in that the pickup rate in tuberculosis is very low. As a result the Regional Hospital Board have decided that the mobile mass radiography service will be withdrawn. Facilities for chest x-ray examination will, however, be continued and will

be provided by static units at all the main hospitals. The static unit at Warwick Road, Carlisle, will continue as before, and it is hoped that open chest x-ray facilities will be available at the new hospital in Penrith when this is completed. In the West Cumberland area it is hoped to be able to provide similar facilities at Workington, Whitehaven and Millom.

TUBERCULOSIS

Table 1 shows the number of notifications in the East Cumberland County area for the past ten years.

Table 1

Year	Pulmonary	Non-Pulmonary
1953	63	18
1954	66	19
1955	56	20
1956	54	10
1957	54	12
1958	47	15
1959	50	11
1960	19	6
1961	8	2
1962	23	2
1963	18	5

Table 2 gives the number of pulmonary and non-pulmonary cases on the Clinic Register at the end of 1963, for the same area.

Table 2.

Pulmonary	Non-Pulmonary
237	29

There has been no change in the programme of therapy in tuberculosis: primary resistance of the organisms to one of the three main drugs has once again not been discovered in any new case of pulmonary tuberculosis during the year. The four chronic cases mentioned in the 1962 Report still remain active in spite of

a modified programme of therapy. Modified therapy means treatment with "second-line" drugs such as Ethionamide, Pryazinamide and Cycloserine. Each of these drugs has serious disadvantages, not the least being the simple failure of patients to continue their programme of treatment. Patients who have had the disease for a very long time, and who have already had long periods of hospital treatment are difficult to treat with these drugs. As long as efficient combined therapy using the three main drugs can be given to new patients the likelihood of any further chronic cases coming into being is possibly remote, at least in this County. The small number of chronic cases in this area, i.e. 4, still remains a problem and one about which we cannot be complacent.

No new drugs have been introduced in therapy; all patients receive combined therapy, and in all patients, both pulmonary and non-pulmonary, treatment is continued for a minimum of 18/24 months. Surgery is being used less and less.

Once again no new case in immigrants was discovered during the year.

Contact work has been continued as in the past, and Table 3 shows the number of new contacts in the East Cumberland County area examined during the year, and of those, the number vaccinated with B.C.G. Vaccine. Routine x-ray examinations of old adult contacts continued to be largely carried out through the mass radiography service.

Table 3.

Year	No. of NEW Contacts seen	No. vaccinated with B.C.G. vaccine	No. of hospital staff additional to Col. 1 and vaccinated with B.C.G. vaccine
1957	1126	143	34
1958	986	155	48
1959	1152	156	50
1960	906	100	39
1961	898	135	43
1962	959	124	32
1963	774	109	38

Table 4 shows the number of beds available to the Chest Service in the whole of the East Cumberland Hospital Management Committee area, together with the number of patients discharged for the past two years.

Table 4.

Hospital	BEDS: Allocation as at 31st Dec., 1963	BEDS: Average daily number of beds available	BEDS: Average daily No. occupied	BEDS: Percentage of bed occupancy	PATIENTS: Discharged	PATIENTS: Average length of stay in days
Cumberland Infirmary						
1962 ...	13	12.4	11.4	92.2%	229	17.4
1963 ...	13	11.5	11.05	96.1%	218	18.4
Blencathra Hospital						
1962 ...	25	25	14.4	57.7%	68	101
1963 ...	25	25	15.67	62.7%	66	73
Longtown Hospital						
1962 ...	26	26	22.3	85.6%	125	66
1963 ...	26	26	23.48	90.3%	145	58

CANCER OF THE LUNG

Table 5 shows the number of new cases of cancer of the lung seen at the chest centre during 1963, and the previous seven years.

Table 5.

Year		East Cumberland
1956	...	11
1957	...	11
1958	...	27
1959	...	31
1960	...	20
1961	...	30
1962	...	29
1963	...	36

Of the 74 cases coming to our notice during 1963 only one was found, after investigation, to be fit for surgery, and thus only palliative treatment was possible for the other 73. Chemotherapy in this disease remains inadequate. Palliative deep x-ray therapy is of considerable value in such cases, particularly in relieving pain and terminating haemoptysis. It has been a simple matter to admit cases requiring palliative deep x-ray therapy to the Department in the Cumberland Infirmary, but unfortunately these facilities will soon be non-existent as it has been decided that such treatment should only be given in Units using Mega-voltage therapy, which, in this area, will be given at Newcastle.

Comparisons have been made in treating operable lung cancer by surgery and Mega-voltage therapy; in the latter the greater penetration of high energy radiation and the increasing dose that could be given to the tumour mass when compared with the conventional x-ray therapy suggested that such tumours could be more effectively treated with Mega-voltage therapy than with conventional radiation therapy. Another important point is that with the better definition of a Mega-voltage beam, the dose received by normal tissues was greatly reduced, and it was generally felt that cure of

the lesion was thus more likely. Recent papers have suggested that in operable cases the results are significantly better with surgery than with Mega-voltage therapy.

As far as palliative measures are concerned, I am unaware of any evidence suggesting that Mega-voltage therapy is more efficient in relieving pain and bleeding in inoperable cases than conventional radiation therapy. It seems a great pity therefore that the local department in the Cumberland Infirmary should have to be closed. Most of our patients with cancer of the lung are middle-aged, of both sexes, and invariably require admission with a view to palliative x-ray therapy for pain and/or bleeding. The Department in the Cumberland Infirmary has served the whole of the Special Area, and patients as far away as Millom, Kirkby Stephen, and Langholm, have been admitted. In future such patients will have to go to Newcastle for this treatment, and many of them, particularly those from the outlying areas in the Special Area, will certainly not be fit to undertake the additional journey involved

I have spoken of lung cancer as this is one of the biggest problems in the Chest Service, but obviously patients with cancers of other sites will be treated likewise, so that the problem of these patients in the Special Area is a very acute one. On humunatarian grounds alone I feel there is a strong argument for the retention of the conventional x-ray therapy department in Carlisle.

APPENDIX III

MASS RADIOGRAPHY

REPORT ON THE WORK OF THE MASS RADIOGRAPHY UNIT DURING 1963

(NOTE: Figures given in brackets throughout the report relate to the corresponding figures for 1962).

Both the Static and Mobile Units were fully operational throughout the twelve months.

Groups Examined

In addition to carrying out surveys at works and factories, surveys of the general public were carried out on 68 occasions. 911 (927) contact cases were x-rayed, 442 from the East Cumberland area and 469 from West Cumberland.

Results

42,630 (41,534) persons were examined by the Units during the year. Of these 987 were referred for clinical examination.

Table 1 shows the number of abnormalities revealed during 1963 throughout the whole of the Special Area.

Table 1.

Abnormalities Revealed—	No. of cases found		Percentage of total examined	
(1) Non-tuberculous conditions:				
(a) Bronchiectasis ...	45	(41)	.11	(.10)
(b) Pneumoconiosis ...	43	(60)	.10	(.14)
(c) Neoplasm ...	24	(34)	.06	(.08)
(d) Cardiovascular conditions	90	(89)	.21	(.21)
(e) Miscellaneous requiring investigation ...	19	(15)	.04	(.04)
(2) Pulmonary Tuberculosis:				
(a) Active ...	25	(36)	.06	(.09)
(b) Inactive requiring supervision ...	62	(77)	.15	(.19)
(c) Active (Previously known) ...	—	(—)	—	(—)

Tables 2 and 3 give a detailed analysis of the work of the Units both Mobile and Static divided as between East and West Cumberland.

Table 2.

MOBILE UNIT	EAST CUMBERLAND							WEST CUMBERLAND							
Source of examination	Doctors' cases	Contact cases	Students	School staff	General Public	Surveys	TOTALS	Doctors' cases	Contact cases	Students	School staff	General Public	Surveys	Mentally defective patients.	TOTALS
Miniature Films	36	387	1,902	210	11,488	7,782	21,805	53	463	803	26	7,595	6,855	308	16,103
Clinical Examinations ...	2	7	10	1	231	111	362	3	14	7	—	214	82	2	322
Active Tuberculosis ...	—	—	—	—	4	1	5	—	2	—	—	6	—	—	8
Inactive Tuberculosis requiring supervision	—	—	—	—	—	—	—	—	2	—	—	35	12	2	51
Bronchiectasis ...	—	—	—	—	7	7	14	—	—	—	—	12	6	—	18
Neoplasms	—	—	—	—	5	1	6	1	—	—	—	—	1	—	2
Pneumoconiosis	—	1	—	—	1	3	5	1	2	—	—	27	3	—	33
Cardiac conditions ...	1	—	—	—	39	3	43	—	2	—	—	17	2	—	21

Table 3.

STATIC UNITS	CARLISLE					WHITEHAVEN				
Source of examination	Doctors' cases	Contact cases	General Public	Employees	TOTALS	Doctors' cases	Contact cases	General Public	Employees	TOTALS
Miniature Films	1,980	55	1,159	619	3,813	340	6	460	103	909
Clinical Examinations	190	2	55	3	250	42	—	9	2	53
Active Tuberculosis	10	—	2	—	12	—	—	—	—	—
Inactive Tuberculosis requiring supervision ...	3	—	1	—	4	4	—	1	2	7
Bronchiectasis	13	—	—	—	13	—	—	—	—	—
Neoplasms	13	—	2	—	15	1	—	—	—	1
Pneumoconiosis	1	—	—	—	1	3	—	1	—	4
Cardiac conditions	20	—	4	—	24	1	—	1	—	2

Table 4 gives the relative figures as between East and West Cumberland for the past eight years. The figures for 1952 have also been included.

Table 4.

Year		EAST CUMBERLAND						WEST CUMBERLAND					
		Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
1952	...	71*	707	9*	245	68	13	80*	423	2*	148	26	117
1956	...	46	338	8	360	37	3	56	258	2	53	15	61
1957	...	37	312	7	368	18	2	24	226	4	72	24	92
1958	...	40	153	10	321	27	2	16	81	4	90	16	125
1959	...	33	40	13	241	37	3	14	24	4	39	15	71
1960	...	21	11	19	120	19	2	18	21	7	23	9	52
1961	...	20	11	24	144	23	4	13	20	5	24	10	42
1962	...	24	14	25	71	22	2	12	63	9	18	19	60
1963	...	17*	4	21*	67	27	6	8*	58	3*	23	18	37

* Compare figures for 1952 and 1963.

Tables 5 and 6 refer solely to the area covered by the East Cumberland Hospital Management Committee. Table 5 shows the number of new cases of pulmonary tuberculosis discovered and Table 6 the number of new cases of neoplasm discovered in each case.

Table 5.

Year	No. of new cases	Number with positive sputum	Percentage of new cases with positive sputum	No. of new cases referred by M.M.R.	Percentage of new cases referred by M.M.R.	Percentage positive sputum cases found by M.M.R.
1956 ...	125	39	31	39	31	18
1957 ...	125	42	34	33	26	29
1958 ...	117	32	27	29	25	9
1959 ...	116	31	27	28	24	6
1960 ...	72	28	39	21	29	18
1961 ...	58	20	34	20	34	20
1962 ...	52	22	42	23	44	24
1963 ...	37	11	30	17	46	45

Table 6.

	1956	1957	1958	1959	1960	1961	1962	1963
No. of cases of neoplasm seen at Chest Centre ...	29	38	59	59	54	64	60	74
No. discovered by M.M.R.	8	7	10	13	19	24	25	21

Comments

These statistics show that mass radiography has continued to play an important role in the discovery of pulmonary tuberculosis and cancer of the lung. Whereas, however, the number of cases of cancer of the lung shows a steady increase with a corresponding increase in the number discovered by mass radiography, there has been a steady fall in the overall number of new cases of tuberculosis and a corresponding fall in the number of these picked up by mass radiography. Of the total number of 42,630 persons examined by the Unit during the year, 9,695 of these had never had a chest x-ray taken previously and as the pick up rate is always higher in those who have never had a chest x-ray examination, one must emphasize that all adults should have an annual chest x-ray examination so that diagnosis of both diseases may be made as early as possible. Pick up rates on the Static Unit are as usual very much higher than on the Mobile Unit, the majority of those persons coming through the Static Unit being either people who already have pulmonary symptoms and are referred by their own doctors or are persons at special risk.

When the mass radiography service was first introduced after the war the object was to find as many cases of pulmonary tuberculosis as possible and every effort was therefore made to examine as many people, particularly workers in industry, as the Units could cope with. The examinations were made easy and convenient to both workers and factories. Since then there has been a gradual decline in the number of new cases of pulmonary tuberculosis dis-

covered and chest centre statistics throughout the country show a substantial decline in the infector pool in the community. General indiscriminate radiography, therefore, in factories and at public sessions is no longer considered necessary and the emphasis of radiography is now directed to the examination of groups in which the rate of tuberculosis picked up is likely to be high such as prevail in Static Units where many of the new cases discovered are referred by doctors. In the Special Area, therefore, it is proposed that routine mobile mass radiography will end in June, 1964, the Static Unit at 1, Brunswick Street, Carlisle, will continue and it is hoped to provide further static facilities at Workington, Whitehaven, Millom and Penrith. As far as East Cumberland is concerned it is suggested that open chest x-ray facilities be provided at the X-ray Department of the proposed new Penrith Hospital.

In addition to groups specially at risk who are examined at the Static Unit at 1, Brunswick Street, Carlisle, we are offering facilities to factories and firms in the City and environs for new entrants to those factories to be examined before taking up employment. When mass radiography first started there were few if any moderate or large factories which did not have cases of tuberculosis picked up during the first surveys and since the last surveys carried out in these factories were unproductive as far as tuberculosis was concerned, it certainly would be a great pity if any new cases of tuberculosis were introduced and thus start infection. It is hoped that all factories, workshops, etc., in the area of Carlisle and its environs, will avail themselves of this service.

The Static Unit now has open sessions every day except Saturday and Sunday and these sessions include one evening session on Wednesdays.

The ending of the mobile mass radiography service is another milestone in the history of the fight against tuberculosis and one cannot let this pass without expressing our appreciation of the facilities, help and general co-operation which have been given us by factory managements. We have been particularly fortunate in this area as all managements and trade union representatives

have shown themselves as anxious as we were to stamp out tuberculosis, and to all who have in any way contributed to the success of our service I would say 'Thank you'.

As heretofore, it is also a pleasure to acknowledge once again the valuable help in arranging surveys given by the local Medical Officers of Health, and the police.

The general practitioners in the East Cumberland area are making fuller use of the Static X-ray facilities and I hope that the additional sessions in operation will make this service more valuable still.

APPENDIX IV

County Council Clinics

Centre	*Address*	*Clinic Services*
Alston ...	Cottage Hospital, Alston. ...	Child Welfare.
Anthorn ...	2 Fell View, Anthorn. ...	Ante-natal, Child Welfare, Dental
Aspatria ...	St. Mungo's Park, Aspatria. ...	Ante-natal, Child Welfare, Dental, Speech Therapy, Orthopaedic
Brampton ...	Union Lane, Brampton. ...	Child Welfare, Chiropody, Dental
Carlisle ...	14 Portland Sq., Carlisle. ...	Child Guidance, Dental, Immunisation and Vaccination, Orthoptic, Speech Therapy, E.N.T., Ophthalmic, Orthopaedic
Cleator Moor ...	Jacktrees Road, Cleator Moor. ...	Ante-natal, Child Welfare, Dental, Orthopaedic
Cockermouth ...	Harford House, Cockermouth. ...	Ante-natal, Child Welfare, Chiropody, Dental, Immunisation and Vaccination, Orthopaedic, Speech Therapy
Dalston ...	Village Hall, Dalston. ...	Child Welfare
Egremont ...	St. Bridget's Lane, Egremont. ...	Ante-natal, Child Welfare, Chiropody, Dental, Hearing Therapy, Chest, Orthopaedic, Speech Therapy
Frizington ...	County Chambers, Frizington. ...	Ante-natal, Child Welfare, Dental
Houghton ...	Village Hall, Houghton. ...	Child Welfare
Keswick ...	13-15 Bank St., Keswick ...	Child Welfare, Dental, Immunisation and Vaccination, Speech Therapy, Ophthalmic, Orthopaedic
Longtown ...	Esk Street, Longtown. ...	Child Welfare, Dental, Chiropody

Maryport ...	24 Selby Tce., Maryport. ...	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, Speech Therapy Orthopaedic
Millom ...	18 St. George's Rd., Millom. ...	Ante natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, Speech Therapy, Surgical, Chest, Gynaecological, Medical, Minor Ailments (G.P's). Ophthalmic, Orthopaedic
Nenthead ...	Overwater, Nenthead. ...	Child Welfare
Penrith ...	Brunswick Square, Penrith. ...	Ante-natal, Child Welfare, Dental, Orthoptic, Speech Therapy, Family Planning, Orthopaedic, Psychiatric
Scotby ...	Village Hall, Scotby. ...	Child Welfare
Seascale ...	Gosforth Rd., Seascale. ...	Ante-natal, Child Welfare, Immunisation and Vaccination
Seaton ...	Miners' Welfare Hall, Seaton. ...	Child Welfare
Thornhill ...	Community Centre, Thornhill. ...	Child Welfare
Wetheral ...	Village Hall, Wetheral. ...	Child Welfare
Whitehaven-Flatt Walks ...	Flatt Walks, Whitehaven. ...	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Chest, E.N.T., Ophthalmic, Orthopaedic
Mirehouse ...	Dent Road, Mirehouse, Whitehaven. ...	Ante-natal, Child Welfare, Dental
Woodhouse ...	Woodhouse, Whitehaven. ...	Ante-natal, Child Welfare, Immunisation and Vaccination

Wigton ...	Birdcage Walk, Wigton.	...	Child Welfare, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Speech Therapy, Orthopaedic.
Workington-Park Lane ...	Park Lane, Workington.	...	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Family Planning, Orthopaedic. Note:—Spastic Therapy Clinics held about three times a year.
Harrington ...	Methodist Hall, Harrington, Workington.	...	Ante-natal, Child Welfare
Westfield ...	St. Mary's Parish Hall, Moss Bay, Workington.	...	Child Welfare